

---

# **Interagency Performance Standards and Practice Guidelines**

---

*State of Hawaii*

**Department of Education  
Office of Curriculum, Instruction and  
Student Support**

**and**

**Department of Health  
Child & Adolescent Mental Health Division**

**Effective July 1, 2006**

**Amended February 2, 2006**

**Printed June 1, 2006**

## **TABLE OF CONTENTS**

<b>INTRODUCTION.....</b>	<b>xi</b>
<b><i>SECTION I: GENERAL PERFORMANCE STANDARDS .....</i></b>	<b><i>1</i></b>
<b>OVERVIEW .....</b>	<b>2</b>
A. ACCESS & AVAILABILITY.....	2
DOE .....	2
CAMHD.....	3
1. EDUCATIONALLY SUPPORTIVE (ES) SERVICES .....	3
2. SUPPORT FOR EMOTIONAL AND BEHAVIORAL DEVELOPMENT (SEBD)	
.....	3
3. MENTAL HEALTH ONLY (MHO).....	3
B. COORDINATION.....	4
DOE .....	4
CAMHD.....	4
C. ASSESSMENTS.....	5
DOE ASSESSMENTS.....	5
1. PSYCHOEDUCATIONAL ASSESSMENT.....	5
2. FUNCTIONAL BEHAVIORAL ASSESSMENT (FBA) .....	5
3. EMOTIONAL BEHAVIORAL ASSESSMENT (EBA) COMPREHENSIVE AND	
ANNUAL UPDATE .....	6
CAMHD ASSESSMENTS .....	7
1. PSYCHOSEXUAL ASSESSMENT .....	7
2. MENTAL HEALTH ASSESSMENT .....	7
D. CAMHD CO-OCCURRING DISORDERS.....	7
E. SERVICE PLANNING .....	8
DOE SERVICE PLANNING .....	8
1. BEHAVIORAL SUPPORT PLAN (BSP).....	8
2. STUDENT SERVICE PLAN (SSP).....	9
CAMHD SERVICE PLANNING .....	10
1. COORDINATED SERVICE PLAN (CSP).....	10
2. MENTAL HEALTH TREATMENT PLAN (MHTP) .....	10
a. TRANSITION PLANNING FOR ADULTHOOD .....	10
b. CRISIS PLANNING.....	11
c. DISCHARGE PLANNING .....	11
d. DISCHARGE SUMMARY .....	11
F. REFERRAL PROCESS FOR SERVICES .....	11
DOE REFERRAL PROCESS.....	11
CAMHD'S REFERRAL PROCESS FOR CONTRACTED SERVICES.....	12
1. REFERRAL ACCEPTANCE.....	12
a. OUTPATIENT REFERRALS .....	12
b. OUT OF HOME REFERRALS.....	13
c. REFERRAL ACCEPTANCE PROTOCOL.....	13

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

G.	CAMHD CONTINUITY OF CARE .....	14
H.	STAFFING .....	15
	DOE STAFFING .....	15
	1. ORIENTATION AND TRAINING .....	15
	CAMHD STAFFING.....	16
	1. ORIENTATION AND TRAINING REQUIREMENTS FOR CAMHD CONTRACTORS .....	16
	2. ORIENTATION AND TRAINING REQUIREMENTS FOR CAMHD DIRECT SERVICE EMPLOYEES .....	18
I.	SUPERVISION .....	19
	DOE SUPERVISION .....	19
	CAMHD SUPERVISION.....	20
J.	EVALUATION OF STAFF PERFORMANCE.....	21
K.	CREDENTIALING REQUIREMENTS .....	21
	DOE CREDENTIALING REQUIREMENTS .....	21
	1. DOE INDIVIDUAL PRACTITIONER CREDENTIALING INFORMATION ...	21
	a. PROFESSIONAL .....	21
	b. DOE BEHAVIORAL HEALTH/SPECIAL EDUCATION PROFESSIONAL .....	22
	c. DOE PARAPROFESSIONAL.....	22
	CAMHD CREDENTIALING REQUIREMENTS.....	23
	1. CAMHD INDIVIDUAL PRACTITIONER CREDENTIALING INFORMATION .....	23
	a. QUALIFIED MENTAL HEALTH PROFESSIONAL (QMHP) .....	23
	b. MENTAL HEALTH PROFESSIONAL (MHP) .....	24
	c. CAMHD TEACHERS IN COMMUNITY-BASED RESIDENTIAL PROGRAMS.....	24
	d. CAMHD PARAPROFESSIONAL.....	25
L.	MEDICATION MONITORING/TRACKING .....	25
	DOE MEDICATION AND MONITORING.....	25
	1. MEDICATION MANAGEMENT .....	25
	2. PROGRESS NOTE.....	25
	CAMHD MEDICATION AND MONITORING .....	26
M.	MAINTENANCE OF SERVICE RECORDS .....	26
	DOE SERVICE RECORD .....	27
	1. PROGRESS NOTES .....	27
	CAMHD SERVICE RECORDS .....	27
	1. PROGRESS NOTES .....	28
	2. CAMHD PHOTO .....	29
N.	SERVICE QUALITY .....	29
O.	MINIMUM REPORTING REQUIREMENTS .....	29
	1. DOE/CAMHD CREDENTIALING TRACKING FORM OF LICENSED PROVIDERS .....	29
	2. PROGRESS REPORT .....	30
	DOE PROGRESS REPORT.....	30

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

CAMHD PROGRESS REPORT: MONTHLY TREATMENT AND PROGRESS SUMMARY (MTPS).....	30
3. QUALITY ASSURANCE (QA) REPORTS .....	31
DOE QA REPORT .....	31
a. QUALITY ASSURANCE SPECIFICATION.....	31
b. OUTPUT AND PERFORMANCE/OUTCOME MEASUREMENTS .....	31
c. SERVICE VERIFICATION .....	31
d. SENTINEL EVENTS AND INCIDENTS .....	32
CAMHD QUARTERLY QA REPORT .....	32
a. SENTINEL EVENTS .....	32
b. GRIEVANCES .....	32
c. STAFFING/PERSONNEL ACTIVITIES .....	32
d. TRAINING AND PRACTICE DEVELOPMENT.....	33
e. CLINICAL SUPERVISION .....	33
f. CREDENTIALING.....	33
g. CLINICAL DOCUMENTATION.....	33
h. PERFORMANCE/OUTCOME MEASURE .....	33
i. FACILITY .....	34
j. STATUS OF CORRECTIVE ACTION/IMPROVEMENT PLANS.....	34
k. CONTRACTOR QA MEETING AGENDA/MINUTES.....	34
4. CAMHD STATE FACILITY LICENSE.....	34
5. CAMHD POLICIES, SCHEDULES, TRAINING CURRICULUM, AND OTHER DOCUMENTS .....	34
6. CAMHD SUMMARY OF LICENSING CORRECTIVE ACTIONS AND ANY REQUIRED DELIVERABLES.....	34
7. CAMHD SENTINEL EVENTS .....	34
8. CAMHD ACCREDITATION .....	34
9. CAMHD WEEKLY CENSUS REPORT ON CLIENT STATUS AND WAITLISTED YOUTH .....	35
10. CAMHD ATTENDANCE AND ENCOUNTER RECORDS .....	35
11. CAMHD TITLE IV-E ADMINISTRATIVE REPORTS.....	35
12. OTHER SPECIFIED REPORTS/DOCUMENTATION PERIODICALLY REQUESTED BY CAMHD.....	35
P. RISK MANAGEMENT .....	35
1. CRIMINAL, CHILD ABUSE, AND BACKGROUND SCREENING .....	35
DOE SCREENING.....	35
CAMHD SCREENING .....	36
2. SAFETY .....	36
3. RESTRAINTS AND SECLUSIONS .....	36
SECLUSION.....	37
MECHANICAL RESTRAINT.....	37
PHYSICAL RESTRAINT .....	37
CHEMICAL RESTRAINT.....	38
ORDERS.....	38
MONITORING.....	39
ASSESSMENT AFTER THE INITIAL INTERVENTION .....	39

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

FOR NON-HOSPITAL-BASED PROGRAMS .....	39
NOTIFICATION .....	39
DEBRIEFING .....	40
4. SENTINEL EVENTS AND INCIDENTS .....	41
5. POLICE.....	41
Q. STUDENT/YOUTH RIGHTS AND CONFIDENTIALITY .....	41
DOE CONSUMER RIGHTS.....	41
CAMHD CONSUMER RIGHTS .....	42
R. COMMUNITY FOCUS .....	42
S. TEAM-BASED DECISIONS.....	43
T. GRIEVANCES/APPEALS.....	43
U. ACCOUNTABILITY/SERVICE STANDARDS .....	43
V. BEDHOLDS AND THERAPEUTIC PASSES .....	43
BEHOLDS .....	43
THERAPEUTIC PASSES .....	44

### ***SECTION II: SERVICE SPECIFIC PERFORMANCE STANDARDS***

#### ***SECTION II - PART A: EMERGENCY MENTAL HEALTH PERFORMANCE STANDARDS***

I. EMERGENCY MENTAL HEALTH SERVICES.....	47
A. 24-HOUR CRISIS TELEPHONE SERVICE .....	47
B. CRISIS MOBILE OUTREACH.....	50
C. CRISIS THERAPEUTIC FOSTER HOME.....	54
D. COMMUNITY-BASED CRISIS GROUP HOME.....	59

#### ***SECTION II - PART B: SCHOOL - BASED BEHAVIORAL HEALTH SERVICES PERFORMANCE STANDARDS***

II. SCHOOL-BASED BEHAVIORAL HEALTH SERVICES .....	66
INTRODUCTION .....	66
A. FUNCTIONAL BEHAVIORAL ASSESSMENTS AND BEHAVIORAL SUPPORT PLANS.....	67
B. EMOTIONAL BEHAVIORAL ASSESSMENTS- COMPREHENSIVE.....	71
C. EMOTIONAL BEHAVIORAL ASSESSMENTS- ANNUAL UPDATE.....	75
D. INDIVIDUAL COUNSELING .....	79
E. GROUP COUNSELING .....	86
F. PARENT COUNSELING/TRAINING.....	92
G. PSYCHIATRIC SERVICES .....	97
1. PSYCHIATRIC DIAGNOSTIC EVALUATION .....	97
2. PSYCHIATRIC MEDICATION EVALUATION .....	102
3. MEDICATION MANAGEMENT .....	105
H. INTENSIVE LEARNING CENTERS .....	108
I. INTENSIVE SERVICES.....	116
1. INTENSIVE INSTRUCTIONAL SERVICES CONSULTATION.....	116
2. PARENT EDUCATION/TRAINING .....	123
J. SPECIAL SCHOOL .....	126
K. COURT/DUE PROCESS HEARING TESTIMONY .....	133

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

L. EDUCATIONAL TEAM PLANNING AND PARTICIPATION .....	135
M. SCHOOL CONSULTATION .....	137

### **SECTION II - PART C: EDUCATIONALLY SUPPORTIVE INTENSIVE MENTAL HEALTH SERVICES FOR IDEA PERFORMANCE STANDARDS**

III. EDUCATIONALLY SUPPORTIVE INTENSIVE MENTAL HEALTH SERVICES .....	139
A. ANCILLARY SERVICES .....	140
B. RESPITE SUPPORTS .....	143
C. PSYCHOSEXUAL ASSESSMENT .....	145
D. INTENSIVE CASE MANAGEMENT .....	149
E. INTENSIVE IN-HOME INTERVENTION .....	153
F. MULTISYSTEMIC THERAPY .....	159
G. RESPITE THERAPEUTIC FOSTER HOME .....	164
H. RESPITE HOME .....	168
I. COMMUNITY MENTAL HEALTH SHELTER .....	172
J. THERAPEUTIC FOSTER HOME .....	176
K. MULTIDIMENSIONAL TREATMENT FOSTER CARE .....	182
L. THERAPEUTIC GROUP HOMES .....	188
M. INDEPENDENT LIVING PROGRAM 18-21 YEARS .....	193
N. INDEPENDENT LIVING PROGRAM 16-18 YEARS .....	198
O. COMMUNITY-BASED RESIDENTIAL LEVEL III .....	203
P. COMMUNITY-BASED RESIDENTIAL LEVEL II .....	209
Q. COMMUNITY-BASED RESIDENTIAL LEVEL I .....	215
R. HOSPITAL-BASED RESIDENTIAL .....	221

### **SECTION II - PART D: SUPPORT FOR EMOTIONAL AND BEHAVIORAL DEVELOPMENT PERFORMANCE STANDARDS**

IV. SUPPORT FOR EMOTIONAL AND BEHAVIORAL DEVELOPMENT .....	227
A. PEER SUPPORT .....	228
B. COMPREHENSIVE MENTAL HEALTH ASSESSMENT .....	232
C. FOCUSED MENTAL HEALTH ASSESSMENT .....	236
D. SUMMARY ANNUAL ASSESSMENT .....	241
E. PSYCHIATRIC EVALUATION .....	244
F. MEDICATION MANAGEMENT .....	248
G. INDIVIDUAL THERAPY .....	251
H. GROUP THERAPY .....	256
I. FAMILY THERAPY .....	261
J. FUNCTIONAL FAMILY THERAPY .....	266
K. PARENT SKILLS TRAINING .....	271
L. TREATMENT SERVICE PLANNING/PARTICIPATION .....	274
M. INDIVIDUALIZED EDUCATION PROGRAM PLANNING/PARTICIPATION .....	276
N. SCHOOL CONSULTATION .....	278
O. CASE CONSULTATION .....	281
P. FAMILY COURT TESTIMONY .....	284
Q. INTENSIVE OUTPATIENT CO-OCCURRING SUBSTANCE ABUSE TREATMENT .....	286

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

R. INTENSIVE OUTPATIENT SERVICES FOR INDEPENDENT LIVING SKILLS .....	291
S. COMMUNITY-BASED CLINICAL DETOXIFICATION.....	297
T. PARTIAL HOSPITALIZATION .....	303
U. COMMUNITY HOSPITAL CRISIS STABILIZATION .....	309
V. ACUTE PSYCHIATRIC HOSPITALIZATION .....	314

### ***SECTION III: INTERAGENCY PRACTICE GUIDELINES***

I. INTRODUCTION .....	320
A. SUPERVISION AND OUTCOME BASED PLAN EVALUATION .....	320
B. INTERVENTIONS AND SUPPORTS .....	323
PRACTICE ELEMENTS .....	323
II. ATTENTION PROBLEMS AND HYPERACTIVITY (e.g., ADHD) .....	323
A. ASSESSMENT PROTOCOLS SPECIFIC TO ATTENTION PROBLEMS AND HYPERACTIVITY .....	323
B. OTHER CONSIDERATIONS .....	324
C. COEXISTING /CO-OCCURRING CONDITIONS .....	324
D. MOST PROMISING PSYCHOSOCIAL INTERVENTIONS .....	324
E. PRACTICE ELEMENTS FOR ADHD.....	325
F. ADDITIONAL CONSIDERATIONS.....	326
G. MOST PROMISING PSYCHOPHARMACOLOGICAL INTERVENTIONS .....	326
III. ANXIETY AND AVOIDANT PROBLEMS AND DISORDERS (INCLUDING PTSD AND OCD).....	326
A. ASSESSMENT PROTOCOLS SPECIFIC TO ANXIETY PROBLEMS AND DISORDERS .....	326
B. OTHER CONSIDERATIONS .....	327
C. COEXISTING/CO-OCCURRING CONDITIONS .....	327
D. MOST PROMISING PSYCHOSOCIAL INTERVENTIONS .....	328
E. PRACTICE ELEMENTS FOR ANXIETY AND AVOIDANCE .....	329
F. ADDITIONAL INTERVENTION CONSIDERATIONS .....	330
G. MOST PROMISING PSYCHOPHARMACOLOGICAL INTERVENTIONS .....	330
IV. PERVASIVE DEVELOPMENTAL DISORDERS (INCLUDING AUTISM) .....	330
A. ASSESSMENT PROTOCOLS SPECIFIC TO PERVASIVE DEVELOPMENTAL DISORDERS .....	330
B. OTHER CONSIDERATIONS .....	332
C. COEXISTING/CO-OCCURRING CONDITIONS .....	332
D. MOST PROMISING PSYCHOSOCIAL INTERVENTIONS .....	333
E. ADDITIONAL INTERVENTION CONSIDERATIONS .....	333
F. MOST PROMISING PSYCHOPHARMACOLOGICAL INTERVENTIONS .....	333
V. CHILDHOOD SCHIZOPHRENIA .....	334
A. ASSESSMENT PROTOCOLS SPECIFIC TO SCHIZOPHRENIA .....	334
B. OTHER CONSIDERATIONS .....	334
C. COEXISTING/CO-OCCURRING CONDITIONS .....	334
D. MOST PROMISING PSYCHOSOCIAL INTERVENTIONS .....	334

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

E.	ADDITIONAL INTERVENTION CONSIDERATIONS .....	334
F.	MOST PROMISING PSYCHOPHARMACOLOGICAL INTERVENTIONS .....	335
VI.	CONDUCT AND OPPOSITIONAL PROBLEMS (INCLUDING JUVENILE SEX OFFENDERS) .....	335
A.	ASSESSMENT PROTOCOLS SPECIFIC TO CONDUCT AND OPPOSITIONAL PROBLEMS AND DISORDERS .....	335
B.	OTHER CONSIDERATIONS .....	336
C.	COEXISTING/CO-OCCURRING CONDITIONS .....	336
D.	MOST PROMISING PSYCHOSOCIAL INTERVENTIONS .....	336
E.	ADDITIONAL INTERVENTION CONSIDERATIONS .....	337
F.	PRACTICE ELEMENTS FOR CONDUCT AND OPPOSITIONAL PROBLEMS.....	338
G.	MOST PROMISING PSYCHOPHARMACOLOGICAL INTERVENTIONS .....	339
VII.	DEPRESSION AND WITHDRAWAL.....	339
A.	ASSESSMENT PROTOCOLS SPECIFIC TO DEPRESSION.....	339
B.	OTHER CONSIDERATIONS .....	339
C.	COEXISTING/CO-OCCURRING CONDITIONS .....	340
D.	MOST PROMISING PSYCHOSOCIAL INTERVENTIONS .....	340
E.	ADDITIONAL INTERVENTION CONSIDERATIONS .....	340
F.	PRACTICE ELEMENTS FOR DEPRESSION AND WITHDRAWAL .....	341
G.	MOST PROMISING PSYCHOPHARMACOLOGICAL INTERVENTIONS .....	341
VIII.	EATING DISORDERS .....	342
A.	ASSESSMENT PROTOCOLS SPECIFIC TO EATING DISORDERS.....	342
B.	OTHER CONSIDERATIONS .....	342
C.	COEXISTING/CO-OCCURRING CONDITIONS .....	343
D.	MOST PROMISING PSYCHOSOCIAL INTERVENTIONS .....	343
E.	ADDITIONAL INTERVENTION CONSIDERATIONS .....	343
F.	MOST PROMISING PSYCHOPHARMACOLOGICAL INTERVENTIONS .....	343
IX.	SUBSTANCE USE.....	344
A.	ASSESSMENT PROTOCOLS SPECIFIC TO CONDUCT AND OPPOSITIONAL DISORDERS .....	344
B.	OTHER CONSIDERATIONS .....	344
C.	COEXISTING/CO-OCCURRING CONDITONS.....	344
D.	MOST PROMISING PSYCHOSOCIAL INTERVENTIONS .....	344
E.	ADDITIONAL INTERVENTION CONSIDERATIONS .....	345
F.	MOST PROMISING PSYCHOPHARMACOLOGICAL INTERVENTIONS .....	345
X.	BIPOLAR DISORDER .....	345
A.	ASSESSMENT PROTOCOLS SPECIFIC TO BIPOLAR DISORDER.....	345
B.	OTHER CONSIDERATIONS .....	346
C.	COEXISTING/CO-OCCURRING CONDITIONS .....	346
D.	MOST PROMISING PSYCHOSOCIAL INTERVENTION .....	346
E.	ADDITIONAL INTERVENTION CONSIDERATIONS .....	346



---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

F.	MOST PROMISING PSYCHOPHARMACOLOGICAL INTERVENTIONS .....	346
XI.	MANAGEMENT OF PSYCHIATRIC MEDICATIONS.....	347
A.	PSYCHOSTIMULANTS .....	348
B.	TRICYCLIC ANTIDEPRESSANTS.....	349
C.	NONTRICYCLIC ANTIDEPRESSANTS .....	350
D.	MOOD STABILIZERS .....	351
E.	ANTIPSYCHOTICS .....	352
F.	ANXIOLYTICS AND OTHERS .....	353
XII.	SUMMARY .....	354
XIII.	REFERENCES .....	356
XIV	TABLE 1: SCIENTIFIC KNOWLEDGE IN PEDIATRIC PSYCHOPHARMACOLOGY ...	357
XV.	EVIDENCE-BASED CHILD AND ADOLESCENT PSYCHOSOCIAL INTERVENTIONS	358
XVI.	EVIDENCE-BASED CHILD AND ADOLESCENT PSYCHOPHARMACOLOGY .....	359
<b>SECTION IV: INTERAGENCY SERVICE INTENSITY GUIDELINES</b>		
I.	INTRODUCTION .....	362
A.	PROCEDURES .....	362
B.	SCHEDULING.....	363
C.	WHO SHOULD ATTEND.....	363
D.	REVIEW PROCESS .....	363
E.	RELATIONSHIP TO CARE COORDINATION RESPONSIBILITY .....	363
F.	RELATIONSHIP TO OTHER SUPPORT SERVICES.....	363
II.	SCHOOL-BASED BEHAVIOR SUPPORT SERVICES FOR EMOTIONALLY &/OR BEHAVIORALLY DISRUPTIVE YOUTH.....	364
III.	INTENSIVE COMMUNITY BASED MENTAL HEALTH SERVICES FOR EMOTIONALLY &/OR BEHAVIORALLY DISRUPTIVE YOUTH .....	365
IV.	OUT OF HOME MENTAL HEALTH TREATMENT SERVICES FOR EMOTIONALLY &/OR BEHAVIORALLY DISRUPTIVE YOUTH.....	366
<b>SECTION V: GLOSSARY</b> .....		368
<b>SECTION VI: APPENDICES</b> .....		391
A.	APPENDIX A: DOE DOCUMENTS.....	392
	DOE DOCUMENT LIST .....	393
1.	COMPREHENSIVE STUDENT SUPPORT SYSTEM (CSSS) .....	394
2.	REQUEST FOR ASSISTANCE FLOWCHART .....	397
3.	CSSS ARRAY OF STUDENT SUPPORT .....	398

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

4.	ARRAY OF SCHOOL COUNSELING/BEHAVIORAL SUPPORTS.....	400
5.	STANDARDS OF PRACTICE	
a.	STANDARDS OF PRACTICE .....	401
b.	FUNCTIONAL BEHAVIORAL ASSESSMENT .....	402
c.	EMOTIONAL BEHAVIORAL ASSESSMENT .....	405
d.	COUNSELING.....	408
e.	PARENT EDUCATION, COUNSELING/TRAINING.....	412
f.	LEAD AND DIRECT A SKILLS TRAINER .....	414
g.	INDIVIDUALIZED INSTRUCTIONAL SUPPORTS .....	416
h.	MEDICATION MANAGEMENT AND PROCUREMENT PROCEDURES .....	423
i.	PSYCHIATRIC DIAGNOSTIC AND MEDICATION EVALUATION .....	426
j.	INTENSIVE LEARNING CENTER.....	429
k.	SPECIAL SCHOOL .....	432
6.	FBA (FUNCTIONAL BEHAVIOR ASSESSMENT) AND BSP (BEHAVIOR SUPPORT PLAN) GUIDE .....	434
7.	FUNCTIONAL BEHAVIOR ASSESSMENT (SAMPLE) .....	435
8.	BEHAVIOR SUPPORT PLAN BRAINSTORMING (SAMPLE) .....	436
9.	BEHAVIOR SUPPORT PLAN IMPLEMENTATION (SAMPLE).....	437
10.	FUNCTIONAL BEHAVIOR ASSESSMENT FORM .....	439
11.	BEHAVIOR SUPPORT PLAN BRAINSTORMING FORM .....	443
12.	BEHAVIOR SUPPORT PLANNING WORKSHEET .....	444
13.	BEHAVIOR SUPPORT PLAN IMPLEMENTATION FORM.....	446
14.	DOE GUIDELINES FOR WATER RELATED ACTIVITIES .....	447
15.	EMOTIONAL BEHAVIORAL ASSESSMENT/PSYCHIATRIC DIAGNOSTIC EVALUATION (FORMAT) .....	451
16.	EMOTIONAL BEHAVIORAL ASSESSMENT: ANNUAL UPDATE/PSYCHIATRIC MEDICATION EVALUATION (FORMAT).....	455
17.	PSYCHIATRIC MEDICATION MANAGEMENT PROGRESS NOTE FORM .....	459
18.	REFERRAL CHECKLIST FOR EMOTIONAL BEHAVIORAL ASSESSMENTS, PSYCHIATRIC DIAGNOSTIC AND MEDICATION EVALUATIONS.....	460
19.	SCHOOL BASED BEHAVIORAL HEALTH QUARTERLY PROGRESS REPORT..	462
20.	SENTINEL EVENT/INCIDENT NOTIFICATION FOR DOE CONTRACTED PROVIDERS .....	463
21.	SERVICE VERIFICATION FORM.....	465
22.	STUDENT SERVICE PLAN .....	466
23.	REQUEST FOR EVALUATION FORM 101 .....	468
B.	APPENDIX B: CAMHD DOCUMENTS	
	CAMHD DOCUMENT LIST.....	470
1.	CASSP PRINCIPLES .....	471
2.	P&P 80.702 – CARE COORDINATION.....	472
3.	P&P 80.614 – REFERRAL ACCEPTANCE PROTOCOL .....	478
4.	EPSDT – ELEMENTS OF EPSDT SCREENS AND PERIODICITY MATRIX .....	484
5.	REFERRAL ACCEPTANCE FORM.....	486
6.	INDEPENDENT PSYCHIATRIST CONSULTATION FORM .....	487
7.	SEBD FACT SHEET .....	489

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

8.	SEBD REFERRAL FORM.....	491
9.	MEDICATION TRACKING FORM .....	493
10.	MEDICATIONS TRANSFER FORM .....	495
11.	SERVICE PROVIDER MONTHLY TREATMENT AND PROGRESS SUMMARY .	496
12.	INSTRUCTION AND CODEBOOK FOR SERVICE PROVIDER MONTHLY TREATMENT AND PROGRESS SUMMARY .....	499
13.	AGENCY AGGREGATED DATA FORM .....	510
14.	AGENCY QUALITY INDICATOR DATA COLLECTION TOOL .....	511
15.	THERAPEUTIC FOSTER HOME PROFILE FORM .....	512
16.	P&P 80.805 SENTINEL EVENTS .....	513
17.	72-HOUR SENTINEL EVENTS REPORT .....	518
18.	SENTINEL EVENT CODES / DEFINITIONS .....	522
19.	WEEKLY CENSUS REPORT ON CLIENT STATUS .....	528
20.	WAITLISTED YOUTH FORM .....	529
21.	CAMHD EDUCATION ATTENDANCE REPORT .....	530
22.	CONTRACTED AGENCY QUARTERLY TRAINING REPORT .....	531
23.	P&P 80.406 CHILD ABUSE AND NEGLECT CHECK .....	532
24.	P&P 80.308.1 RECREDENTIALING OF LICENSED PROFESSIONALS.....	536
25.	P&P 80.603 GRIEVANCES AND GRIEVANCE APPEALS.....	562

## INTRODUCTION

On July 1, 2002, a collaborative effort between the **Department of Health's** (DOH) Child and Adolescent Mental Health Division (CAMHD) and the **Department of Education** (DOE) was launched with the implementation of the ***Interagency Performance Standards & Practice Guidelines (IPSPG)***, which became more commonly known as the *Blue Book* or *Green Book* depending on the color of the cover, which represents the edition and year of publication.

The *IPSPG* is an integrated manual, jointly developed by DOH-CAMHD and the DOE, for use in the development and provision of behavioral health/mental health services to students who a) have been certified as qualifying under Individuals with Disabilities Educational Act (IDEA) for special education services; and/or qualifying under Section 504 – Subpart D of the Rehabilitation Act of 1973; and who are in need of related behavioral/mental health services to benefit from their free and appropriate public education; and b) students who meet the eligibility requirements for the DOE/CAMHD Support for Emotional and Behavioral Health (SEBD) program. These standards and guidelines are designed to define service content standards, and to improve the efficiency and effectiveness of the school-based behavioral health services and the array of intensive mental health services.

The DOE, through its Comprehensive Student Support System (CSSS) model (See Appendix A-1) and School-Based Behavioral Health Program, provides a supportive educational environment for all children by providing varying levels of support including prevention, risk-reduction, early intervention, and specially designed Behavior Support Plans. SBBH program staff includes Behavioral Specialists, School Counselors, School Social Workers, Clinical Psychologists and School Psychologists, who are located within schools/complexes. They assist school teams in understanding students' challenging behaviors and disabilities and in developing strategies and supports to help students benefit from their education. Parents, as members of the IEP/MP teams, participate in developing the IEP/MP goals and objectives, Functional Behavioral Assessment and Behavioral Support Plans. School teams (IEP and MP), work collaboratively with other SBBH program staff (School Psychologists, Clinical Psychologists, Mental Health Supervisors, School Social Workers, and Psychological Examiners) to properly address the student's functioning and develop classroom strategies, as well as, behavioral supports and interventions.

When more intensive supports and services are needed than the DOE can provide through its SBBH Program or when a student is eligible for SEBD benefits, the DOH-CAMHD through its Branches provides intensive case management services (also referred to as care coordination services). In addition to the intensive case management services provided by the Mental Health Care Coordinator (MHCC), CAMHD Branches are able to procure contracted services. As students who require the level of services provided by CAMHD are often involved with other child-serving agencies (e.g. Department of Human Services-Child Welfare Services, Family Court, DOH's Developmental Disabilities Division (DDD), Alcohol and Drug Abuse Division (ADAD), Maternal Child Health (MCH), Early Intervention Program, Public Health Nursing branch; and DHS-Division of Vocational Rehabilitation), a coordinated service planning process is used in guiding the intensive case management services provided by the MHCC and in addressing all areas of need. All of these listed public agencies are invited to the CSP, IEP meetings, Interagency Peer Review meetings, and District-level Quality Assurance meetings as appropriate. State Quality Assurance Team meetings include representation from the Department of Health- Child and Adolescent Division, DOH-Developmental Disabilities Division, DOH-Early Intervention Program, Department of Human Services-Child Welfare Services, and Department of Education. Other public agency representation on the Interagency Quality Assurance Committee is continuously sought.

## INTERAGENCY PERFORMANCE STANDARD AND PRACTICE GUIDELINES

---

This current manual is an updated version of the initial IPSPG, and is designed to define service content standards and to improve the efficiency and effectiveness of the school-based behavioral health services and the array of intensive mental health services. It is intended for use by both DOE and DOH employees and contracted providers in developing individualized plans and providing behavioral/mental health services for students/youth. The DOE developed Standards of Practice (SOP) to assist staff when considering IEP/MP related behavioral/mental health services. Whereas, the SOPs guide the process to assist in the determination of need for services, this manual defines the standards and guidelines for those services.

***Unless otherwise granted a written waiver from the Departments, all CAMHD and DOE contracted provider agencies and their employees/subcontractors, are required to comply with all elements of this manual when providing services. Contracted provider agencies must adhere to the specific contracts which delineate additional detailed requirements for each of the services.***

If any of the performance standards or practice guidelines present a conflict with requirements of IDEA or Section 504-Subpart D, then all federal regulations will supercede this manual.

***SECTION I:***  
**GENERAL PERFORMANCE STANDARDS**

## **SECTION I: GENERAL PERFORMANCE STANDARDS**

### **OVERVIEW**

The General Performance Standards are requirements for all Department of Education (DOE) School-Based Behavioral Health (SBBH) and Child and Adolescent Mental Health Division (CAMHD) services, and apply to each of the specific services. They are set forth as a basis to guide effective practices in the delivery of behavioral health supports and services for eligible students/youth in the State of Hawai'i. In Hawai'i's integrated system, supports and services are provided in accordance with all regulations as required by Individuals with Disabilities Educational Improvement Act 2004 (IDEA)/Section 504 of the Individuals with Disabilities Act (504), and with active involvement of families and communities in alignment with the Hawai'i Child and Adolescent Service System Program (CASSP) principles (See Appendix B-1).

In order that students/youth receive the greatest benefit from services, the DOE and CAMHD intend to utilize evidence-based treatment interventions and supports whenever possible. The commitment to use evidence-based interventions is an important basic principle in a system that strives to produce positive outcomes in an accountable way, and to continually update and improve itself based on empirical evidence. In the "Evidence-Based Services (EBS) Committee Biennial Report – Summary of Effective Interventions for Youth with Behavioral and Emotional Needs, Fall 2004" the CAMHD, the DOE, the University of Hawai'i, and community experts committed to a process of continual literature review and regular updating of practice guidelines based on that review. The Practice Guidelines are based on the most current information on evidence-based interventions/treatments and are periodically updated as empirical support for evidence-based interventions evolves over time.

All services are expected to comply with applicable Federal and State of Hawai'i Laws and Administrative Rules. Contractors are expected to adhere to all performance standards, contractual obligations, and official DOE and CAMHD policies and procedures.

### **A. ACCESS & AVAILABILITY**

DOE and CAMHD are committed to providing timely service planning and access to an array of services. DOE and CAMHD services, whether they are delivered by employees or contracted providers, are expected to be initiated and provided in a timely and consistent manner, as guided by the standards and practice guidelines defined in this manual.

#### **DOE:**

When parents or professional staff within educational setting believe a student is at risk or in need of services or supports in order to reduce or eliminate emotional and/or behavioral barriers to learning, they can refer the student by submitting a CSSS Request for Assistance Form to the Student Service Coordinator (SSC) assigned to the school the student attends. The Request for Assistance Form initiates the informal team process. The Core Team interventions and decision-making may lead to a request for further evaluation, but that is not automatic. It is appropriate for the team to begin to identify the function of a student's behavior through an information gathering process. (It is not appropriate for the team to immediately refer for an emotional behavioral health assessment, without going through an initial information gathering process.) Based upon that initial information, interventions, and responses to interventions, referrals may be made for a more comprehensive evaluation through the Request for Evaluation Form 101 (See Appendix A-23).

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

The SSC assists the student and his/her family through the processes and procedures involved in assessment, planning, service provision and, if needed, evaluation. The student's primary caregiver(s) are always included in each step of assessment, planning, and service provision.

The review of the information gathered during Functional Behavior Assessment process will allow the school-based or interagency team to develop hypotheses regarding influences on the student's behavior and to develop a plan for support and intervention. The array of supports and strategies that counseling, school-based behavioral health personnel and others will implement will include a range of interventions from teacher consultation, accommodations and modifications of classroom structures and procedures, through application of more intensive and specific behavioral approaches for students with disabilities, and as necessary, a variety of clinical interventions. (Refer to Heading F: DOE Referral Process)

SBBH services delineated in this document are delivered in accordance with an Individualized Education Program (IEP) or in rare circumstances, a Modification Plan (MP) based upon decisions of the team. DOE services are provided by DOE personnel; DOE contracted services are utilized when necessary.

### **CAMHD:**

CAMHD serves three (3) distinct populations as described below and eligibility determination as well as service array varies according to type of eligibility. Youth may be eligible in more than one (1) population category.

#### **1. Educationally Supportive (ES) Services**

Access for ES services is done through DOE and the IEP process for students whose complex needs extend beyond their school-based educational program and whose community and home environments require additional specific support via their IEP. Students who have been identified as requiring intensive mental health services are enrolled with the CAMHD Branch located in the school district of their home school. They are assigned a Mental Health Care Coordinator (MHCC) at that time. The student may, and often will, continue to receive SBBH services and supports in conjunction with the intensive services provided through the CAMHD Branch. The service array for this population is in Section II, Part C, Educationally Supportive (ES) Services.

#### **2. Support for Emotional and Behavioral Development (SEBD) Program Services**

Access and determination of eligibility for SEBD services is through the SEBD referral process (See Appendix B-7). The SEBD Referral form (See Appendix B-8) is submitted to the CAMHD Branch within the youth's home district. A determination of eligibility is then made. CAMHD provides services to youth who meet the eligibility requirements for the SEBD program. These services are based on team determinations of what each youth needs in order to improve his/her emotional and/or behavioral functioning. They can receive all of their mental health services through CAMHD. The service array for this population is described in Section II, Part C, Educationally Supportive (ES) Services and Section II, Part D, Support for Emotional and Behavioral Development (SEBD) Program services.

#### **3. Mental Health Only (MHO)**

Access for these services most commonly occurs for youth who present within the juvenile justice system. However, there are occasionally other youth who may also warrant time-limited services. Youth, ages three (3) to eighteen (18) years, with emotional and/or behavioral



---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

challenges who are not eligible through either of the above two criterion groups (ES or SEBD), but who are determined to be in need of mental health services by the CAMHD Medical Director. These youth include those who have been found eligible for services under Section 504 of the Rehabilitation Act by their home school, uninsured youth, and youth with private insurance but uncovered service needs. These youth may be serviced only within the general funds legislatively appropriated and available after the ES and SEBD youth have been served. The CAMHD Medical Director based on medical necessity determines the type and mix of services provided.

### **B. COORDINATION**

All DOE students and CAMHD youth will have their services coordinated by a care coordinator from the respective department to ensure timely, appropriate and coordinated service delivery.

#### **DOE:**

Students served through DOE are assigned a Care Coordinator (CC) to facilitate access to services. This CC arranges for timely implementation of all levels of service (with the exceptions of emergency and urgent interventions) as guided by this manual.

The role of the CC is to serve as the central point of coordination and communication for eligible students and their families within the context of the team model. The CC manages all aspects of the IEP/MP, ensuring the delivery of services identified by the IEP/MP team. Services provided through DOE will have a single CC. This CC will be identified after the completion of either the IEP or 504 MP meeting. The CC will be a member of the student's educational team.

#### **CAMHD:**

For youth served by CAMHD, the Mental Health Care Coordinator (MHCC) is responsible for engaging the youth and family, referring the youth for appropriate services, maintaining contact with the youth/family, ensuring the timely and efficient delivery of quality services, and continuous monitoring of the effectiveness of interventions. The youth's MHCC is responsible for convening an initial Coordinated Service Plan (CSP) meeting within thirty (30) days of eligibility determination, or immediately if the youth has immediate needs and assuring service delivery within 30 days of identification for routine services. The MHCC coordinates regular home visits, school visits, and community contacts as indicated in CAMHD P&P 80.702 "Care Coordination" (See Appendix B-2). When appropriate, responsibilities also include coordination of care with Family Court, and Department of Human Services and other state and community agencies. Contractors are expected to participate in the CSPs when their involvement will help to inform effective planning for individual youth. The MHCC is responsible for facilitating the integration, coordination, and monitoring of behavioral health services across programs and domains and to initiate necessary adjustments to services when needed through the team based process.

Contractors are responsible for coordination of services that are provided within their agency. Coordination and communication are particularly important in settings where there is multiple staff providing services for a youth. Contractors are also expected to coordinate efforts with the youth's school and community settings. Ongoing engagement, communication and coordination with families are a necessary practice as families are an integral part of the therapeutic process.

### C. ASSESSMENTS

DOE and CAMHD believe that behavioral and clinical assessment procedures are selected based on the complexity of the youth's problem, as well as the judgment of those individuals working with the youth during the initial stages of information gathering. Behavioral and clinical approaches are designed to provide complementary information, and each draw from evidence-based strategies in the identification and management of childhood behavioral and or mental health problems. The superiority of any one method is not assumed; methods chosen should be based on the problems, goals, and needs of the identified youth and shall begin with the simplest strategies first, unless otherwise warranted. Each department uses a variety of tools to determine the interventions needed. Recommendations describe and address the strengths and needs of the student/youth and do not specify a particular service, service provider, and program or eligibility status.

#### **DOE: Assessments**

The type or sequence of initial assessments that a youth receives should be based on an initial gathering of information and a team decision regarding the complexity of the youth's problem and the need for particular types of information.

#### **1. Psychoeducational Assessments**

Psychoeducational Assessments include observing, interviewing, and collecting data from a variety of sources to be included in the decision-making process. These sources may include both traditional and alternative assessment strategies, a variety of psychological, cognitive, and educational assessment methods validated for the problem area under consideration, including formal and informal test administration, behavioral assessment, curriculum-based measurement, interviews, and ecological/environmental assessment.

#### **2. Functional Behavioral Assessments (FBA)**

FBAs are necessary components to serving students with challenging behaviors. A timely and comprehensive FBA is completed prior to planning and implementation of supports and services. An FBA allows for an assessment of the reasons for behaviors as well as suggestions for ways to adequately and effectively address these behaviors. FBA is a process with ongoing behavioral assessments regularly conducted to address significant changes, current status, and consequent recommendations.

Following referral, a school-based student support team will be convened to plan and implement a comprehensive FBA focusing on the student and the contexts within which problem behaviors have been observed. In the case of students receiving or referred for special education or 504 services, the school-based team will be an IEP/MP Team.

FBA is a framework for gathering both general and specific information regarding the influences on a student's behavior. The primary purpose of gathering the information is to use it in designing a comprehensive Behavior Support Plan (BSP). The FBA is complete when five (5) main outcomes have been achieved, as follows:

- a. Clear descriptions of the problem behaviors, including classes or sequences of behaviors that frequently occur together;
- b. Identification of the events, times and situations that predict when the problem behaviors are most likely to occur and/or least likely to occur across the full range of typical daily routines;

- c. Identification of the consequences that maintain the problem behaviors (that is, what functions the behaviors appear to serve for the person);
- d. Development of one or more summary statements or hypotheses that describe specific behaviors, a specific type of situation in which they occur, and the outcomes or reinforcers maintaining them in that situation;
- e. Collection of data that support the summary statements that have been developed;
- f. Refer to the FBA/BSP formats and samples in Appendix A, 6-13.

The FBA culminates in a BSP that assists the team with strategies and supports. All students served jointly by DOE and CAMHD shall have a BSP from his/her home school.

### 3. Emotional Behavioral Assessments (EBA) Comprehensive and Annual Update

An EBA is requested when the Student Support Team (SST), IEP, or MP Team, in consultation with the DOE's psychologists, determines that additional information provided by the EBA is needed to determine behavioral/mental health needs and recommendations. EBAs are part of the set of information that informs planning and strategies for individualized interventions. EBAs are intended to assist teams to **diagnostically** understand a student's presenting symptoms so that the most effective treatment interventions can be applied. EBAs are informed by the student's developmental course, family history, school functioning, social roles, substance use, psychiatric and medical history, degree of success or failure of previous interventions, current Diagnostic Statistical Manual (DSM) IV version diagnoses on all five (5) axes, prognosis, and recommendations for intervention. Recommendations incorporate student/family strengths, are evidence-based, and focus on the identified strengths and needs of the student. Furthermore, recommendations should describe and address the needs of the student and not specify a particular service, program, provider or eligibility status.

This broad view of assessment is consistent with the concepts and practices of behavioral assessment and can also incorporate diagnosis, *if needed*, as one of many organizational components for guiding the planning of services and supports. It should be noted, however, that ***diagnosis is not required for the selection and implementation of an evidence-based approach. In some cases it may be helpful, in others, less so.***

If seeking to make a clinical diagnosis (which is necessary for CAMHD intensive mental health services), clinicians are encouraged to use structured or semi-structured clinical interviews. In addition, the use of parent and child measures of general behavior problems e.g., Behavior Assessment System for Children, 2<sup>nd</sup> Edition (BASC-2) components, Strengths and Difficulties Questionnaire (SDQ), Achenbach System of Empirically Based Assessment (ASEBA) School-Aged Forms, the Child and Adolescent Functional Assessment Scale (CAFAS; Hodges, 1990) are to be included along with other relevant measures so as to inform diagnosis, if warranted, and interventions. During the course of intervention, service providers (i.e. Teachers, Behavioral Specialists, School Counselors, School Social Workers, School and Clinical Psychologists, and contracted providers) will conduct ongoing measurement and review, which shall be used for adjusting intervention.

If an FBA has been conducted, it should be reviewed when conducting the EBA. If an FBA has not previously been conducted, it is necessary to conduct one to develop a plan of supports for the student. DOE conducts or contracts the initial EBA. Thereafter, students jointly served by DOE and CAMHD will have an EBA Annual Update.

### **CAMHD: Assessments**

#### **1. Psychosexual Assessment**

CAMHD provides a **Psychosexual Assessment** for both the ES and SEBD populations. This assessment is a specialized evaluation service, involving a strengths-based approach to identify the youth's needs in the specific context of sexually abusive behaviors. The Psychosexual Assessment is designed to build on the prior mental health assessment, using specialized psychometric instruments designed to assess sexual attitudes and interest as well as a risk assessment.

#### **2. Mental Health Assessments**

Additionally, CAMHD provides three (3) mental health assessments for the SEBD population:

- a. **Comprehensive Mental Health Assessment,**
- b. **Focused Mental Health Assessment,** and
- c. **Summary Annual Assessment.**

These assessments are specifically necessary to understand a youth's presenting symptoms, diagnosis, strengths, needs and environment so that the most effective treatment interventions can be applied. Assessments are part of the set of information that is used in planning strategies for treatment interventions, and are necessary prior to initiation of an individualized treatment intervention. Assessments are informed by the youth's developmental course, family history, school functioning, social roles, substance use, psychiatric and medical history, degree of success or failure of previous interventions, current Diagnostic Statistical Manual (DSM) version diagnoses on all five (5) axes, prognosis, and recommendations for treatment within the context of a long-range view of the youth. Measures of the youth's behavior and functioning [e.g. Child and Adolescent Functional Assessment Scale (CAFAS) or Preschool and Early Childhood Functional Assessment Scale (PECFAS), ASEBA Checklist for Parent, Teacher, and Youth Self-Report form] are to be included along with other relevant measures so as to inform treatment recommendations.

The Comprehensive Mental Health Assessment is conducted or contracted if a current assessment does not already exist for an SEBD youth. Thereafter, all Contractors must do a Summary Annual Assessment as specified in the specific level of care standard for SEBD youth in their care at the time the annual assessment is due for SEBD youth who have received at least three (3) months of services from the Contractor. The Summary Annual Assessments address significant changes, current status and consequent recommendations. CAMHD conducts or contracts for a Focused Mental Health Assessment when there is a specific therapeutic question to be addressed. All recommendations incorporate youth/family strengths, are evidence-based, and based on the identified needs of the youth.

If Contractors choose to use an electronic format for assessments, this electronic format must contain all the elements required by CAMHD.

### **D. CAMHD CO-OCCURRING DISORDERS**

Many youth receiving services from CAMHD have mental health disorders that co-occur with substance abuse, mental retardation, developmental disorders, or medical impairments (e.g. blindness, deafness, diabetes, etc.) Consequently, the presence of co-occurring disorders is assessed with all youth at the point of initial evaluation, as well as routinely during the course of on-going treatment. It is essential for youth to receive services appropriate to their strengths and needs. It is required that all Contractors will provide integrated treatment for co-occurring disorders.

### E. SERVICE PLANNING

All youth served by DOE and/or CAMHD will have their intervention/treatment directed by a service plan that supports the use of Evidenced-based Services (EBS) and Least Restrictive Environment (LRE). CAMHD service planning is an individualized and ongoing process that is youth guided and family/guardian centered.

All treatment/service plans [BSP/Mental Health Treatment Plan (MHTP)/Coordinated (CSP)] must be developed with the student/youth (when appropriate) and parent/guardian involvement. Each plan encompasses:

- Specific goals, measurable objectives, target dates to reach the objectives, and appropriate interventions to achieve these objectives;
- Strengths, and needs driven;
- Utilizes evidence-based strategies and interventions;
- A proactive crisis plan reflective of strategies to avert potential crises, ensure safety using specific and appropriate strategies already known to staff for implementation to manage situations without placement disruptions. In the event a student/youth's behavior is deemed to be a risk to self or others, the school or contracted agency's clinical professional staff must be involved in assessment and determination of appropriate courses of actions. Crisis plans that include natural consequences (e.g. police involvement) should define the positive behavioral supports that should be implemented and exhausted prior to police involvement. Schools and agencies must have written protocols in place for managing crises including management of school-level crisis by school personnel whenever possible.
- A transition/exit/discharge plan that clearly describes the supports and services necessary for a successful and smooth transition to and from significant events in the student/youth's life. Anticipated challenges and barriers are addressed proactively. This plan reflects the overall and long-term goals and objectives of the BSP/SSP/CSP/MHTP anticipating and addressing transitions involving schools, grade levels, providers/teachers, family moves, and reintegration into community and school or return to community-based services from more restrictive treatment services. Transition plans clearly address the process of movement from one level of intensity of services to another including discharges, referrals, intake processes and needed supports during transitions. Student/youth may not be discharged or terminated from formal behavioral/mental health services without agreement from the involved CAMHD Branch, MHTP and IEP team. Transition plans may be developed only with the concurrence of the IEP/MHTP/CSP team through a thoughtful and supportive transitional process.

#### **DOE: Service Planning**

##### **1. Behavioral Support Plan (BSP)**

The primary purpose of any assessment is to increase the effectiveness and efficiency of behavior support plans (BSPs). There should always be a direct and logical connection between the gathering of assessment information and the development or modification of BSPs. BSPs developed for referred students should always fulfill the following five (5) criteria:

- a. The plan should indicate how staff, family or support personnel would change the context within which problem behaviors occur;
- b. The plan should be directly based on all relevant assessment information;

- c. The plan should be technically sound; that is, consistent with the principles and laws of human behavior;
- d. The plan should be a good fit with the values, resources, and skills of the people responsible for implementation; and
- e. The plan should identify evidence-based approaches to behavior change.

**BSPs shall be detailed and contain the following elements:**

- a. Antecedent and setting event modifications;
- b. Teaching of alternative skills using research based practice;
- c. Consequence strategies to strengthen alternative skills, reduce the pay off for the problem behavior, and crisis prevention/intervention;
- d. Lifestyle interventions that include long-term maintenance of skills;
- e. Implementation date of the Behavior Support Plan;
- f. Delineation of who is responsible for each intervention;
- g. Criteria to evaluate progress;
- h. Crisis management plan, if needed; and
- i. Transition plan.

An IEP/MP team, including the student (as appropriate), family/legal guardian, MHCC (if CAMHD is involved), and others familiar with the student identify strengths and needs based on assessments and other data. The IEP/MP team develops a BSP to address the student's strengths and needs. The BSP includes specific goals, measurable objectives, target dates to reach objectives, and appropriate interventions to achieve these objectives. The BSP includes a crisis plan identifying specific actions to take in case of an emergency or high-risk situations, and a plan to prepare for a smooth transition to eventual termination of services. School and CAMHD support teams (if involved) meet regularly to review services and progress, and modify plans and interventions, as needed, to appropriately meet the needs of the student.

## **2. Student Service Plan (SSP)**

The development, implementation and adjustment of the SSP is the responsibility of the service provider in collaboration with the teacher. Student service planning is a collaborative process with close oversight by the professional supervisor and Special Education teacher. The SSP must address the student's behavioral IEP/MP goals/objectives selected for the provider by the school, and all related sections of the BSP. SSPs are specific to the individual providers (DOE employee and contracted) delineate the evidence-based strategies, projected intervention timelines, transition plan, crisis plan, progress monitoring and outcome measures which are appropriate to address the student's IEP/MP goals and objectives that the school has selected for the provider to address. The SSP includes a transition/exit plan.

The development of the SSP should be a collaborative process between the teacher and service provider and should be reviewed with the student (when appropriate). The SSP to address the goals and objectives identified by the school should be submitted to the IEP/MP Care Coordinator. Services should not be initiated without the written service plan and plan should be provided within two (2) weeks of referral. It is the role of the service provider to regularly monitor student progress, refine understanding of the student's strengths, needs and goals and adjust interventions as needed, in collaboration with the teacher, at least every thirty (30) days. Transition/exit plans shall be updated within the SSP based on such reviews.

### **CAMHD: Service Planning**

#### **1. Coordinated Service Plan (CSP)**

A CSP meeting is convened by the MHCC within thirty (30) days of youth's eligibility determination. The CSP is built upon the strengths of the youth and family and is developed with full engagement and involvement of youth, family/guardian, and key individuals involved in the youth's life including existing or potential service providers. The CSP uses resources available through the service system and those naturally occurring in the youth's family and community. By definition it includes full participation of schools and other public agencies. CSP planning is guided by a long-term holistic view of the youth's life. The purpose of the CSP is to identify the specific strategies that will achieve broadly defined goals for the youth and family, and to integrate strategies across all those involved. The MHCC shall convene CSP meetings every six (6) months, or as clinically indicated and if there is a change in situation, in order to assure that the youth's needs are continually addressed and that service planning is modified as necessary.

#### **2. Mental Health Treatment Plan (MHTP)**

The development, implementation, review, revision and adjustments to the MHTP are the responsibility of the service provider. MHTP is individualized for each youth and is an ongoing collaborative process driven by the family/guardian and youth that includes the Contractor, family and the MHCC. MHTPs must be directly linked to achieving goals in a youth's IEP and/or CSP. They are to identify evidence-based treatment interventions that are the most promising options for delivering positive treatment outcomes for a youth's individual goals and objectives. Team members shall reference the practice guidelines (in Section III of this manual) when identifying specific treatment strategies. Progress on plans shall be tracked continuously and treatment revised as necessary with CAMHD employee collaboration. Observations and assessments following intake shall culminate in a comprehensive MHTP inclusive of expected intensity of treatment and treatment timelines, crisis and transition plans and expected outcomes. Initial plans should be developed at intake based on all available information, with the comprehensive MHTP developed within seven (7) days of intake (except where otherwise specified in the Service-Specific standards) or prior to admission.

Specific treatment strategies and services delivered by Contractors are clearly described in a MHTP. It is the role of the Contractor to regularly monitor and adjust treatment plans, with input from the youth, family/guardian, MHCC and members of the youth's team. Contractors must coordinate with family/significant others and with other system of care staff such as education, juvenile justice, and child welfare as needed to plan and provide services. Treatment strategies shall be reviewed at least monthly and plans shall be reviewed with the entire team at least quarterly (except where otherwise specified in the service-specific standards). The goal of all treatment is to improve the youth's emotional, behavioral and functional status such that the youth may experience an improved degree of emotional, behavioral and functional stability.

- a. **Transition Planning for Adulthood:** Planning for a youth's transition to adulthood should begin early, e.g. ages 15-17. Youth and strength-driven goals should be continually refined and achieved in the following six (6) areas:
  1. Living arrangement/personal management
  2. Vocational/educational
  3. Mental health and medical
  4. Community/social experiences
  5. Financial support and
  6. Employment.

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

Transition to adulthood planning and implementation should be documented in the youth's CSP and/or MHTP for all youth aged seventeen (17) years and older.

- b. **Crisis Planning** is tailored to the individual's known or potential high-risk situations that specifically address setting events, triggers, preventive as well as reactive interventions is an expected component of the MHTP that build off the crisis component in the CSP. The crisis plan components will address problematic behaviors utilizing the known strengths and preferences of the youth to reduce or eliminate the high-risk situations and assure youth's safety. Crisis plan components must focus on early intervention into the known high-risk situations to reduce the need to take reactive steps. The use of police or crisis hotline services will be utilized only after all preventive strategies and program policies have been followed.
- c. **Discharge Planning** begins at the time of admission to ensure that any challenges are recognized, addressed and resolved well before the anticipated discharge date. Contractors, MHCC, youth/family/guardian and other involved parties are expected to work together in this process. The discharge component of the MHTP should specifically and measurably spell out the discharge criteria and projected timeline for meeting it consistent with the discharge criteria in the CSP. At least two (2) months prior to the projected discharge date, all involved parties are expected to reconfirm discharge plans, discharge dates, transitions, new admission dates, etc., to avoid unnecessary delays.
- d. **Discharge Summary:** The Contractor must submit a written discharge summary to the appropriate CAMHD Branch on all student/youth within *one (1) week* of service termination. A preliminary discharge summary may be necessary in emergency situations if imminent services are needed. The discharge summary shall include at least the following components:
  - The duration of service provided by the contractor and the level(s) of care,
  - The reason(s) for discharge,
  - History of medication use in the contractor's program and discharge medications;
  - Information about the status of the youth in relation to the prescribed mental health treatment plan. This should include information about the youth's adjustment to the program/service, significant problems and concerns that arose during the treatment episode and significant youth and family accomplishments in the course of the treatment. This section should highlight interventions and/or coping strategies that were especially effective and areas of strength upon which future providers can build;
  - Description of the transition process, including where the student/youth is expected to live after discharge and any work done with the planned new treatment providers and/or caregivers to facilitate the transition; and
  - Planned aftercare services (include name of receiving agency and planned level of care) and recommendations regarding future treatment.

### F. REFERRAL PROCESS FOR SERVICES

#### DOE: Referral Process

The Department of Education's Comprehensive Student Support System (CSSS) provides an array of student support services that identifies the current resources available at the school, complex, and state level in the five levels of student support. The array of student support services ensures that the supports provided and the delivery process correspond to the severity, complexity, and



frequency of each student's needs. Each level increases in intensity or specialization of service, with basic support for all students at Level One, informal additional support through collaboration at Level Two, Individualized school and community-based programs at Level Three, specialized services from DOE and/or other agencies at Level Four, and intensive and multiple agency services at Level Five. With CSSS, students in need of behavioral health/mental health services access CSSS Level One through Five services through a Request for Assistance or Request for Evaluation or their IEP/MP. The DOE Standards of Practice (SOPs) assist the school teams with the process when IEP/MP related behavioral/mental health services are considered.

(Please refer to the Standards Of Practice in the Appendix A-5, a-k)

Students in need of IEP/MP related behavioral health/mental health services, are provided CSSS Level Four or Five SBBH services by school-based providers or, at the discretion of the DOE, contracted providers. Upon the IEP/MP team's determination of a student's need for service, the team will complete a referral packet that includes all data considered in the decision (IEP/MP, FBA/BSP, BASC-2, attendance, grades, discipline data, consent, Prior Written Notice, etc.) to assist the service provider to deliver meaningful services.

### **CAMHD: Referral Process for Contracted Services**

CAMHD provides an array of mental health services through its Branches and contracted providers. The MHCC is a vital link in the referral process and makes referrals to contracted provider agencies based on a full review of the youth's current strengths, needs and as indicated by the admission criteria in the service specific standard as described in the IPSPG. The referral must be made within three (3) business days after the determination of strengths and needs through the youth's CSP and/or IEP and with written consent from the youth/family to release information. The MHCC will ensure that services are initiated in a timely manner. Routine services must be initiated within thirty (30) days of need identification.

All contracted services require prior authorization from CAMHD before service can be provided. With the exception of Emergency Services that must be provided immediately and Urgent Services that must be provided within twenty-four (24) hours of identified need, all contracted CAMHD services require prior written authorization. Without service authorizations Contractors cannot bill for services rendered. The MHCC is responsible to initiate prompt authorization of services.

It is expected that all youth will have full access to needed services. The role of the MHCC is to make referrals to agencies based on a full review of the youth's current strengths and needs and to ensure that services are initiated in a timely manner. If CAMHD youth from one (1) island is referred to and accepted by an out of home provider on another island, CAMHD will pay for the travel costs for admission, discharge and for CAMHD Branch approved therapeutic passes.

#### **1. Referral Acceptance**

The Contractor will be expected to accept all appropriate service referrals in accordance with contractual requirements. All referrals will include explanation of the purpose of treatment, the goals to be achieved via treatment, anticipated duration of treatment, and the discharge/transition criteria. Within three (3) working days of need identification, the MHCC will submit complete referrals as follows:

- a. **Outpatient Referrals:** referral packets to outpatient providers (except for MST) will contain:
  - Outpatient Services Referral Application
  - Referral-Acceptance form (See Appendix B-5)
  - Current CSP

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

- Current CAFAS
  - IEP (as applicable)
  - Current mental health/emotional behavioral assessment (within twelve (12) months);
  - Current FBA (if applicable)
  - Any recent admission/discharge summaries (if applicable)
- b. **Out of Home Referrals:** referral packets to appropriate out of home providers will include the following:
- Out of Home Services Referral Application
  - Referral-Acceptance form (See Appendix B-5)
  - Current CSP
  - Current CAFAS
  - IEP (as applicable)
  - Current mental health/emotional behavioral assessment (within twelve (12) months);
  - Current FBA (if applicable)
  - Any recent Admission/Discharge Summaries and mental health evaluations from previous out-of-home placements, as relevant.
  - Tuberculosis (TB) test results (See TB Test in Glossary)
  - Physical Exam according to Medicaid Early Periodic Screening, Diagnosis, and Treatment (EPSDT) standards and periodicity schedule (See Appendix B-4)
- c. **Referral Acceptance Protocol:**
- The referral acceptance process for out-of-home referrals is described in CAMHD Policy and Procedure (P&P) 80.614 "Referral Acceptance Protocol" (See Appendix B-3). The Contractor for out-of-home services will be expected to follow the referral acceptance process as outlined in P&P 80.614. This process includes the following:
- Within two (2) working days of receipt of the referral packet from the MHCC, the Contractor shall complete and return to CAMHD the Referral Acceptance Form (See Appendix B-5) found in the referral packet to confirm a date for initiation of services.
  - If there are no beds available, the Contractor shall indicate an anticipated admission date that must be no later than the earliest projected discharge date of youth currently being served by the agency. The Contractor will put all youth accepted for an out-of-home program but not yet receiving services due to the lack of contracted bed capacity on the waitlist via the Weekly Census Report on Client Status (See Appendix 19).
  - If beds are available, the admission date shall be as soon as possible. Otherwise, CAMHD will view the youth as being rejected by the Contractor.
  - If, for any reason, a Contractor believes a youth is not appropriate for their level of care, the Contractor must complete a written justification summary from it's Clinical Director and then submit to the Branch's Clinical Director. Within seventy-two (72) working hours, the Branch Clinical Director will review and discuss the concerns with the Contractor's Clinical Director in an attempt to resolve the issues. If the Contractor Clinical Director and Branch Clinical Director come to an agreement that the level of care is appropriate, the Contractor will give the MHCC an anticipated date for the initiation of services.
  - If the concerns cannot be resolved in this manner, the Contractor has the option to request an independent evaluation. The evaluation needs to be completed within fourteen (14) working days at the Contractor's expense. The independent evaluator must be an American Board of Medical Specialties board certified Child and Adolescent

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

Psychiatrist who has no association with either the Contractor or CAMHD and must be approved, in advance, by the CAMHD's Medical Director. The contractor must complete the "CAMHD Independent Consultation Form" (See Appendix B-6) and submit it to the CSO. The CSO will fax the Medical Director's approval or disapproval to the Contractor within three business days of receipt of the form.

- If the independent evaluation determines that the level of care is not appropriate, the Branch and its Clinical Director will accept and review the independent psychiatrist's recommendations. The CSP team will determine the appropriate level of care and send out referral packets to other appropriate providers. CAMHD will reimburse providers the cost of an independent evaluation if the level of care is determined to be inappropriate and CAMHD procedures have been followed for the procurement of the independent evaluation.
- For Outpatient Service Contractors, there is no waitlist. Services are expected to begin as soon as possible at least within fourteen (14) days of acceptance.
- CAMHD reserves the right to execute contractual action if the Contractor is unable or unwilling to meet the needs of CAMHD youth.

### G. CAMHD AND CONTINUITY OF CARE

Contractors will be expected to provide all youth accepted for contracted services with continuity of care until the youth meets the criteria for appropriate discharge or transition to another level of care indicated in team decisions.

For Out-of-Home services, the Contractor may not abruptly terminate services or eject a youth from out-of-home services. As outlined in the CAMHD P&P 80.614 "Referral Acceptance Protocol" (See Appendix B-3), if a Contractor seeks to terminate services for a youth already in out-of-home program:

- The Contractor is required to complete a full internal review that includes a review documented by the contractor's psychiatrist.
- The Contractor is required to report the results of this review to CAMHD and the MHTP team prior to any further action being taken.
- If a Branch receives notification that a Contractor wants to eject a youth, the Branch Clinical Director will contact the Contractor's Clinical Director to review and discuss the issue. If the Contractor's Clinical Director and the Branch Clinical Director come to an agreement that the level of care continues to be appropriate, the Contractor is expected to maintain the youth in its program.
- If the Branch Clinical Director and the Contractor's Clinical Director are not in agreement, the Contractor's Clinical Director has the option to request an independent assessment, at the Contractor's cost, from a Hawai'i licensed, American Board of Medicine Specialties board certified Child and Adolescent Psychiatrist, who is independent of the Contractor and CAMHD. The Contractor must complete the "CAMHD Independent Consultation Form" (See Appendix B-6) for the CAMHD Medical Director's approval of the independent consultant. The Contractor is expected to keep the youth until the result of the independent evaluation.
- If the independent evaluation determines that the current level of care is no longer appropriate, the Branch will accept the determination and initiate appropriate and timely transition services for the youth. The Contractor will be requested to maintain the youth for at least ten (10) days per requirements of the consumer appeal process and to allow for transition preparation.

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

- CAMHD will reimburse providers the cost of an independent evaluation if the level of care is determined to be inappropriate and CAMHD procedures have been followed for the procurement of the independent evaluation.
- If the independent evaluation determines that the level of care continues to be appropriate, the Contractor is expected to maintain the youth in its program.

CAMHD reserves the right to execute contractual action if the Contractor is unable or unwilling to meet the needs of CAMHD youth.

### H. STAFFING

To ensure quality of services provided, all contracted providers must adhere to their respective professional standards as set forth in professional practice guidelines and standards, ethical principles, and codes of conduct in addition to the following requirements.

#### **DOE: Staffing**

##### **1. Orientation and Training**

- a. DOE personnel receive ongoing professional development.
- b. DOE contracted provider agencies are responsible for providing appropriate training for their direct services staff, agents, and volunteers on the use of evidence-based interventions within an educational setting for the student target populations they serve.
- c. DOE contracted providers and agency staff members providing direct services must have attended, and have documentation to the effect that he or she has completed at least forty (40) hours of annual DOE approved professional development. Such professional development must be directly related to his or her work responsibilities.
  - Within the required forty hours of professional development, all contracted providers and agency staff members must have at least thirty (30) hours of basic training including, but not limited to, crisis field assessment and intervention, suicide assessment, risk assessment, clinical protocols, documentation, and knowledge of community resources, as well as training regarding court processes and legal documents relative to emergency procedures, plus specific legal issues governing informed consents. Such basic training must be completed prior to performing crisis outreach services.
- d. DOE contracted providers and agency staff members providing direct services must have at least twenty-four (24) hours of orientation, as approved by the DOE, completed before beginning service delivery. The twenty-four (24) hours of orientation shall include:
  - IDEA and Hawai'i Administrative Rule (HAR) Chapter 56 requirements, including procedures and eligibility criteria;
  - Section 504 and HAR Chapter 53 requirements, including procedures and eligibility criteria;
  - Family Educational Rights and Privacy Act and HAR Chapter 34 requirements;
  - An understanding of educationally relevant interventions and recommendations related to the target population; and
  - An understanding of applicable contract requirements.

These twenty-four (24) hours can be applied towards the forty (40) hours of ongoing professional development required for the year.

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

- e. DOE contracted providers and agency staff members providing direct services must also receive information and training regarding the following topics:
  - HAR Chapter 19 procedures and requirements;
  - State laws regarding child abuse and neglect reporting, reporting criminal behavior and threats regarding suicide and homicide;
  - Crisis intervention procedures, including suicide precautions;
  - A review of Hawai'i CASSP Principles;
  - A review of the Comprehensive Student Support System (CSSS); and
  - An understanding of team-based decision-making.
- f. DOE contracted provider agencies must provide documentation of all training sessions and professional development which shall include:
  - The name of the in-service (or topic of session);
  - The name of the instructor; and
  - Date, place and time of in-service.Individuals must have signed in on official in-service registration sheets. Team meetings and supervisory sessions may not be substituted for professional development.

### **CAMHD: Staffing**

#### **1. Orientation and Training Requirements for CAMHD Contractors:**

- a. Contractors are responsible for providing appropriate training for their staff/contracted consultants on the use of evidence-based treatments and services for the CAMHD youth populations they serve.
- b. CAMHD will offer training on select evidence-based treatments and services for provider agency staff/contracted consultants, and will offer consultation and peer supervision on the appropriate use of those treatments and services.
- c. CAMHD will provide Contractors with information, curricula and/or treatment manuals on select evidence-based treatments and services.
- d. CAMHD Clinical Services Office staff will be available to Contractors to review and provide guidelines and recommendations on curricula and other training materials developed by provider agencies on treatments and services used in services for CAMHD youth.
- e. Contractors must designate a staff person responsible for staff and/or sub-contracted provider training in all other aspects of the delivery of services. The Contractor's trainer(s) is/are responsible for providing and/or arranging for the provision of training and documentation of all staff training, to include:
  - An outline of the discussion points;
  - The topic, name and credentials of trainer;
  - Names and titles of trainees that attended the training;
  - The date, time, place and duration of the training; and
  - An evaluation of the quality and effectiveness of the training.
- f. The Contractor must have a specific training plan detailing how and when staff will be trained.

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

- g. At least forty (40) hours of training are required every year for all full time direct service staff. Those working fifteen (15) hours or less may reduce to twenty (20) hours annually.
- h. At a minimum, each Contractor shall provide all new employees, or sub-contracted personnel, twenty-four (24) hours of orientation to the organization within their first thirty (30) days of employment and/or contract. The orientation process must be completed prior to serving youth. These twenty-four (24) hours can be applied towards the forty (40) hours of ongoing professional development required for the year. The orientation must include:
- An understanding of the agency's mission and goals;
  - A review of agency policies and procedures;
  - Orientation to the population served by the program and the model of care of the program
  - An understanding of all laws and regulations regarding confidentiality including Health Insurance Portability and Accountability Act (HIPAA) requirements;
  - A review of agency structure, lines of accountability, and authority;
  - An understanding of the employee's job description;
  - A review of State laws regarding child abuse and neglect reporting, reporting criminal behavior, and threats regarding suicide and homicide;
  - Non-coercive including positive behavioral support techniques;
  - Evidence-based treatment approaches
  - Crisis intervention procedures, including suicide precautions;
  - An overview of IDEA;
  - A review of Hawai'i CASSP principles;
  - Clinical Record Documentation requirements;
  - CAMHD reporting requirements;
  - Clients rights and responsibilities;
  - CAMHD sentinel events documentation and reporting requirements; and
  - Safety of clients and staff.
- i. All staff providing direct services to youth must annually attend, successfully complete, and document in their personnel file at least forty (40) hours of training, in service, and/or approved continuing education professional development seminars and/or conferences with curricula tailored to the mental health treatment focus of children / adolescents and/or their families. First Aid and Cardiac Pulmonary Resuscitation (CPR) training/recertification also qualify.

The documentation for in-service training must include:

- Name, date, place, and duration of the training;
- The topic of the training and an outline of the discussion points;
- Name/credentials of the instructor and of the organization sponsoring the training; and
- Names and titles of trainees who attended the training.

The documentation for outside training attended must include:

- The name, date, place, and duration of the training;
- A brochure or conference agenda;
- Information about the professional organization that approved the training for continuing education;
- Name(s) and title(s) of the staff member(s) who attended the training; and

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

- Certificates of continuing education credits or certificates of attendance when available.
- j. Treatment team meetings and supervision, although expected, do not apply towards the required forty (40) hours.
- k. These training requirements apply to all personnel providing direct services to youth including sub-contractors and consulting staff (e.g. psychiatrists, psychologists, etc.)
- l. Qualified Mental Health Professionals (QMHP) that require continuing education for license renewal may submit evidence of license renewal for documentation of ongoing professional development.

### **2. Orientation and Training Requirements for CAMHD Direct Service Employees**

CAMHD clinical staff (Branch Chiefs, Clinical Directors, Clinical Psychologists, Mental Health Supervisors and Mental Health Care Coordinators) working in CAMHD Branches must successfully complete the following training within ninety (90) days of hire:

- a. Engagement Skills (Clinical Directors and Clinical Psychologists are exempted from this training):
  - Review and practice of interviewing/listening skills;
  - Review and practice of solution focused questions;
  - Stages of change;
  - Working through resistance;
  - Meeting facilitation; and
  - Interagency Collaboration.
- b. Intensive Case Management (Clinical Directors and Clinical Psychologists are exempted from this training):
  - System of Care including CAMHD mission, and strategic plan;
  - Review of Hawaii's CASSP;
  - Orientation to the population served and CAMHD service delivery model;
  - Understanding of all laws and regulations regarding confidentiality;
  - Review of State laws regarding child abuse and neglect reporting;
  - Overview to evidence-based treatment and best practices;
  - Overview of IDEA; and
  - Evidenced based treatment.
- c. Coordinated Service Planning:
  - Strengths assessment;
  - Strengths-based planning;
  - Transition planning; and
  - Creating a crisis plan.
- d. Child and Adolescent Functional Assessment Scale (CAFAS) certification;
- e. CAFAS Re-certification once every two years for all CAMHD clinical staff;
- f. Child and Adolescent Service Intensity Instrument (CASII-formerly CALOCUS);

- g. Achenbach System of Empirically Based Assessment (ASEBA);
- h. Use of Clinical Standards;
- i. CAMHD Orientation:
  - An understanding of agency's mission and goals;
  - A review of agency structure, line of accountability and authority; and
  - Understanding of all laws and regulations regarding confidentiality including Health Insurance Portability and Accountability Act (HIPAA) requirements.

### I. SUPERVISION

Both DOE and DOH are committed to quality service through regular, ongoing, strength-based, skill building supervision of all staff that provides direct services to students/youth. The DOE, CAMHD, and each Contractor shall have clear lines of accountability and a clearly described supervision structure for all employees and independent contractors.

#### **DOE: Supervision**

Qualified DOE personnel who are in positions whose class specifications or job descriptions describe professional supervision and/or professional support for DOE staff who deliver school-based behavioral health services as part of their assigned duties and responsibilities may provide professional/technical supervision. This may include DOE Clinical Psychologists, School Psychologists, or other designated SBBH supervisors who have clinical training and experience in clinical supervision and behavioral interventions.

All direct service providers shall have a supervision plan based on a needs assessment completed by their respective supervisor. Documentation shall include dates and duration of the supervision sessions, name and position classification or credentials of the supervisor, goals and interventions, and summary of the sessions. Documentation shall be included in the individual's supervision file and must be consistent with the most recent supervision sessions and supervision status.

Regular case reviews are a part of supervision to ensure effective and efficient interventions for students and families served. The frequency of the case reviews is dependent on the level of care as set forth in the service standards. Service plans, goals and objectives must be reviewed and outcomes from interventions utilized must be assessed for information to process for continued or revised course of intervention, depending on the outcomes. Supervision is also expected to include the review of records, Integrated Special Education Database (ISPED) or other specified data collection system entries, development of and evaluating the effects of evidence-based services and plans for staff development and professional growth.

Contracted full time staff and subcontracted service providers shall receive, at a minimum, two (2) hours per month of individual supervision by a qualified behavioral/mental health professional utilizing a combination of methods such as case reviews, direct observation, coaching, and role modeling to improve the level of staff skill. DOE employee service providers shall receive a combination of individual and group professional supervision/professional support, at a minimum, two (2) hours per month, by a qualified behavioral/mental health professional utilizing a combination of methods such as case reviews, direct observation, coaching, and role modeling to improve the level of staff skill. The amount and frequency of supervision may be reduced as authorized by the



---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

supervisor on the basis of documented individual aptitude, experience, and satisfactory performance.

### **CAMHD: Supervision**

Contractors must have policies and procedures and the mechanism to ensure supervision of all direct services and professionals by a QMHP and paraprofessional staff by a QMHP or a MHP who is supervised by a QMHP. The Contractor is responsible for maintaining and tracking supervision records.

All personnel (employees or subcontractors) must have an individualized supervision plan based on a needs assessment completed by their respective supervisor. Documentation must include dates and duration of the supervision sessions, name and credentials of supervisor, goals and interventions, and summary of the sessions. Documentation must be included in the individual's supervision file and must include documentation of follow-up and consistency from previous supervision sessions.

Regular case reviews must be a part of supervision to ensure effective and efficient treatment for youth and families served. The frequency of the case reviews is dependent on the level of care as set forth in the service standards.

Supervision does not include training or administrative discussions. Supervision does include utilizing a combination of methods such as case reviews, direct observation, coaching, and role modeling to improve the level of staff skill.

A QMHP shall participate in peer reviews at least two (2) hours per month as evidenced by documentation in their supervision file. Two (2) hours for each one hundred sixty (160) hours of work may be adjusted for part-time professionals QMHP's may credit regular participation in CAMHD's Evidence-Based Services Committee (EBS) or appointment to and regular participation in the CAMHD Professional Activities Review Committee (PARC) towards the QMHP supervision requirement. Documentation of attendance shall be maintained by the QMHP and submitted to Contractor for inclusion in the credentialing file.

A QMHP shall supervise the equivalent of no more than seven (7)\* full-time MHP's or paraprofessionals. An MHP shall receive at least three (3) hours of supervision a month from a QMHP. At least one (1) hour must be individual, clinical, client-specific supervision and two (2) hours may be group supervision.

An MHP shall supervise the equivalent of no more than seven (7)\* full time paraprofessionals. Paraprofessionals must receive at least four (4) hours of supervision a month from a QMHP or a MHP who is supervised by a QMHP. At least one (1) hour must be individual, clinical, client-specific supervision and three (3) hours may be group supervision.

Paraprofessional employees who work fifteen (15) hours or less a week at an agency, are required to receive at least two (2) hours of supervision a month. At least one (1) hour must be individual, clinical, client-specific supervision and one (1) hour may be group supervision.

Case reviews must be a part of each supervision hour. Treatment plan goals and objectives must be reviewed. Outcomes from interventions utilized must be assessed for information to process for

---

\* Reflects RFP amendment on February 2, 2006 changing supervision maximum load from six to seven.

continued or revised course of treatment, depending on the outcomes. Supervision is also expected to include the development of and evaluating the effects of evidence-based services and plans for staff development and professional growth. Supervision sessions must be documented in writing including participants, content, date and length of the supervision session.

### J. EVALUATION OF STAFF PERFORMANCE

All CAMHD, DOE, and Contractor shall have a process for evaluation of staff performance that includes a review of qualifications (i.e., an assessment of the employee's capabilities, experience, and satisfactory performance), reports of complaints received including resolutions, corrective actions taken, and supports provided to improve practice and to continue to monitor the staff evaluation process.

### K. CREDENTIALING REQUIREMENTS

Both DOE and DOH are committed to ensuring that staff are competent and qualified to provide the intervention/services to students/youth as evidenced by meet the following departmental credentialing requirements.

#### **DOE: Credentialing Requirements**

- Services may be provided by qualified DOE personnel who are in positions whose class specifications or job descriptions describe counseling, behavioral health and/or educational services as part of the assigned duties and responsibilities.
- DOE contracted providers, including employees, agents, and volunteers who provide direct services to students, must be fully credentialed prior to beginning service delivery. They must have completely met initial credentialing requirements through the submittal of required documentation and primary source verification of criminal history background checks, employment history, pre-professional history, and licensure requirements, if applicable.
- DOE contracted provider agencies must maintain written policies and procedures, subject to DOE approval, that govern the credentialing and re-credentialing of its employees, agents and volunteers.
- DOE contracted provider agencies must maintain personnel files of the training, supervision, appropriate credentialing, and ongoing monitoring of all employee, agent, and volunteer performance.
- DOE contracted provider agencies must submit personnel updates, on a monthly basis, to reflect any changes in staffing (i.e., new hires, terminations, changes in credentialing)

#### **1. DOE Individual Practitioner Credentialing Information**

##### **a. Professional**

Individual(s) with any of these qualifications can provide professional supervision/support: Qualified DOE personnel who are in positions whose class specifications or job descriptions describe professional supervision and/or professional support for DOE staff who deliver school-based behavioral health services as part of their assigned duties and responsibilities may provide professional/technical supervision. These may include DOE School or Clinical Psychologists and other SBBH supervisors who have clinical training and experience in clinical supervision and behavioral interventions or Special Education Teachers.

**OR**

1. An individual who possess a Doctorate of Education with a specialty in the areas of special education, psychology or speech pathology with having at least one (1) year of

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

experience working with students with special needs in an educational setting and have knowledge and experience of behavioral approaches.

**OR**

2. An individual who possess a Masters of Education with a specialty in the areas of special education, psychology or speech pathology with having at least five (5) years of experience working with students with special needs in an educational setting and have knowledge and experience of behavioral approaches.

**OR**

3. A current Hawai'i-licensed psychiatrist; board certified by the American Board of Psychiatry and Neurology (ABPN); and board certified in Child/Adolescent Psychiatry.

**OR**

4. An individual who possesses a current Hawai'i license in Psychology, Social Work, or Marriage and Family Therapy (LMFT) having at least three (3) years of experience in behavioral approaches.

**OR**

5. An individual who possesses Social Work Certification, or is a Diplomate in Clinical Social Work (DCSW) or Board Certified Diplomate (BCD) having at least three (3) years of experience in behavioral approaches.

**OR**

6. An individual who possesses a current Hawai'i license and certification to practice as an Advanced Practice Registered Nurse (APRN) having at least three (3) years of experience in behavioral approaches.

**OR**

7. A current Hawai'i-licensed Mental Health Counselor, as of 2005, having at least three (3) years of experience in behavioral approaches.

**b. DOE Behavioral Health/Special Education Professional:**

1. The delivery of special education, counseling and/or behavioral health services may be provided by qualified DOE personnel who are in positions whose class specifications or job descriptions describe special education, counseling and/or behavioral health services as part of the assigned duties and responsibilities (i.e. Special Education Teachers, Behavioral Specialists, School Counselors, School Social Workers.)

**OR**

2. Professionals who meet the staffing requirements for the specific levels of services as delineated in the DOE SBBH contracts.

**c. DOE Paraprofessional:**

At a minimum, paraprofessionals must have a two-year degree from an accredited university or institution of higher learning or meet Federal No Child Left Behind (NCLB) requirements. Any additional training should be available from the agency's supervisory and training infrastructure. NCLB requirements are:

1. Option 1 - 48 credits
  - Credits must be 100 level or higher in any subject area.
  - If earned after June 30, 2003, credits must include three (3) credits in Math and three (3) credits in English.
  - Must be earned from a regionally accredited institution.
  - Agencies must have all transcripts on file.

**OR**

2. Option 2 - Associate's Degree
  - Degree must be earned with 100 level or higher courses.

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

- For employees who earned a degree prior to January 8, 2002, the degree may include less than 100 level courses.
- Must be earned from a regionally accredited institution.
- Agencies must have all transcripts on file.

OR

3. Option 3 – DOE compliance
  - Has met NCLB requirements under DOE guidelines and training.

### **CAMHD: Credentialing Requirements**

Credentialing requirements apply to all individuals providing direct services including sub-contractors of a Contractor. All Contractors shall have written policies and procedures that reflect their responsibility to credential and re-credential their direct care staff, sub-contracted individuals, and clinical supervisory staff prior to provision of services. Contractors shall be guided by CAMHD's credentialing policies and procedures in developing their policies and procedures. Primary sources of information shall be verified by Contractors as a function delegated by CAMHD.

- All professionals contracted or employed by Contractors to provide direct services to youth and families shall be fully credentialed prior to provision of services to clients. They must have completely met initial credentialing requirements through submittal of required documents and satisfactory verification of primary sources including, but not limited to, employment history, reference verification, criminal background checks and child abuse and neglect checks.
- Re-credentialing shall occur at least every two (2) years to ensure continued compliance with credentialing requirements including but not limited to internal provider and CAMHD reporting on performance, grievances, and involvement in sentinel events, licensing requirements, malpractice coverage and claims history, as well as child abuse and neglect clearances. Refer to CAMHD P&P 80.308.1 "Re-credentialing of Licensed Health Care Professionals" (See Appendix B-24) for items that need re-verification.
- Contractors shall establish and maintain an electronic tracking system, in the format prescribed by CAMHD, to ensure prompt and accurate reporting of current staff and contractors as well as terminations. Evidence of Contractors' accountability is exhibited through the submission of the CAMHD Monthly Credentialing Report that is due to CAMHD's Credentialing Office by the 15<sup>th</sup> of each month (or the previous work day if the 15<sup>th</sup> falls on a weekend). Contracted agencies' compliance with this requirement is used in the yearly delegation of credentialing agency oversight evaluation.
- Individual credentialing files for each direct care and supervisory employee and subcontractors shall be established separately from general personnel files.
- Physician continuing education requirements are outlined by the State Professional and Vocational Licensing requirements for continuing education and will not be individually monitored by CAMHD. The renewal of a physician's licensure by the Board of Medical Examiners shall constitute completion of all required continuing education requirements.

### **1. CAMHD Individual Practitioner Credentialing Information**

#### **a. Qualified Mental Health Professional (QMHP):**

1. Must be a current Hawai'i-licensed psychiatrist; board certified by the American Board of Psychiatry and Neurology (ABPN); or board eligible in Child/Adolescent Psychiatry.

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

QMHP Psychiatrists in hospital-based settings must be ABPN board certified in Child/Adolescent Psychiatry.

**OR**

2. A Clinical or Educational Psychologist with a current Hawai'i license/certification in Psychology.

**OR**

3. A licensed Advanced Practice Registered Nurse (APRN) certified as a Psychiatric Clinical Nurse Specialist with a current Hawai'i license/certification.

**OR**

4. A Hawai'i licensed Clinical Social Worker (LCSW).

**OR**

5. A Hawai'i licensed Marriage and Family Therapist (LMFT).

**OR**

6. A Hawai'i licensed Mental Health Counselor (LMHC) at such time inclusion is incorporated into the Medicaid State Plan Amendment and Contractors are officially notified by CAMHD.

**b. Mental Health Professional (MHP):**

1. A physician in training in an ACGME (Accreditation Council on Graduate Medical Education) accredited residency program in Child and Adolescent Psychiatry under program faculty supervision,

**OR**

2. A Ph.D. or Psy.D. in Clinical, Counseling or School Psychology from a nationally accredited university who is not currently licensed in the State of Hawaii,

**OR**

3. A Hawai'i licensed Social Worker (LSW),

**OR**

4. Must have a Master's degree from a nationally accredited university as a national board-certified behavioral analyst, marriage and family therapist, mental health counselor, psychologist, social worker, school psychologist, or psychiatric nurse,

**OR**

5. A Ph.D. or Psy.D. student in clinical psychology studying in an accredited program under program faculty supervision,

**AND**

- Must have at least one (1) year of full-time, clinically supervised progressive work experience inclusive of residency, internship, or practicum in the care or treatment of youth in a mental health or educational setting (experience may be substituted with certificates in a specialty such as Certified Substance Abuse Counselors (CSAC).

**AND**

- Must be supervised by a QMHP.

**c. CAMHD Teachers in Community-based Residential Programs**

The need for specialized educational services for CAMHD youth residing in CBR's require qualified, agency employed/contracted teachers who are:

1. Licensed in Special Education with training in educating students who exhibit a combination of severe social, emotional and behavioral deficits,

**OR**

2. Licensed in related service areas to include (but not limited to) Speech language Pathologist, Occupational Therapists and others as identified in the IEP,

**AND**

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

- To ensure appropriate family involvement, the Contractor is responsible for providing interpreters for families whose limited English proficiency or mode of communication would inhibit their ability to meaningfully participate in the student's education.

### **d. CAMHD Paraprofessional**

1. Personnel with a Bachelor's degree from a nationally accredited university in Psychology, Social Work, Nursing, Counseling, Education, or Special Education.  
**OR**
2. Personnel with a degree less than a Bachelor's level from a nationally accredited university in either Psychology, Social Work, Nursing, Counseling, Education, or Special Education with at least one (1) year of full-time, clinically supervised work experience in the care or treatment of children or adolescents in a mental health or educational setting.  
**OR**
3. Personnel with a high school diploma who have completed or complete within three (3) months of hire a childcare worker training course that includes at least 50 hours of instruction. The University of Oklahoma model that Maui Community College uses is an example. This course should utilize experiential learning methods (e.g. role-played situations) in addition to traditional educational methods such as lecture and group discussion. It should stress CASSP principles and strength-based approaches to helping children and youth. Topics covered should include: understanding basic concepts in child development, skills for building positive relationships with youth, skills for providing discipline and skills for creating a positive environment or milieu. The participants should evaluate the training experience and a well-qualified instructor should teach it. Contractors are encourage to provide this kind of training experience to all new paraprofessional workers, including those with some college background.

## **L. MEDICATION MONITORING/TRACKING**

Youth on psychoactive and other prescription medications require careful coordination and oversight.

### **DOE: Medication and Monitoring**

#### **1. Medication Management shall include all of the following:**

- a. Assessing the student's ongoing need for medication;
- b. Determining overt physiological effects related to the medications used in the treatment of the student's psychiatric condition, including side effects;
- c. Consulting with parent and school regarding behavioral effects of medication;
- d. Determining psychological effects of medications used in the treatment of the student's psychiatric condition;
- e. Monitoring compliance with prescription medication;
- f. Renewing prescriptions;
- g. Documentation of informed consent, including a signed description of potential benefits and possible side effects of the prescribed medication, must be placed in the record prior to initiation of medication. The consent must be signed and dated by the student's parent/legal guardian; and
- h. Submitting the written Psychiatric Medication Management Progress Note

#### **2. A Progress note must be placed within the student's agency record, with a copy sent to the IEP/MP care coordinator, within twenty (24) hours of the date of service, to include:**

- a. Name of student;

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

- b. Date and actual time the services were rendered;
- c. Place of service;
- d. Name of medication, dosage and intervals when medication is to be administered;
- e. Side effects or adverse reactions that the student should be monitored for and the side effects or adverse reactions;
- f. Conditions in which the student is refusing or unable to take medications as ordered or if the student is compliant in taking medications as prescribed; and
- g. Whether the medication is effectively controlling symptoms utilizing the Psychiatric Medication Management Progress Note. (See Appendix A-17)

### **CAMHD: Medication and Monitoring**

For contracted services that include medication monitoring, careful coordination and oversight by the out-of-home service Contractor is required including at least monthly monitoring for:

- Drug interactions,
- Side effects,
- Medical complications,
- Lab test requirements, and
- Follow-up requirements.

More frequent monitoring is required during medication titration or with the occurrence of serious side effects. Medication Monitoring services includes communication with Contractor's Registered Nurse, Contractor childcare staff and parent/guardian/foster parent. Every physician contact, related to medication/monitoring must be documented in progress notes. (See Appendix B, 9 & 10) for sample, optional Medication Tracking Form and Medications Transfer Form that can be used to assist with medication tracking process).

Overall supervision and oversight by the out-of-home Contractor's Hawai'i Licensed Registered Nurse (RN) is required when psychoactive medications have been prescribed. If non-RN staff make medications available, they must be trained by the Contractor's RN. The Contractor's Nurse Medication Training Protocol must be approved by the Office of Health Care Assurance (OHCA) prior to delegating resident medication to any direct care staff that do not possess medical licenses. All direct care staff who are delegated this function must be trained and supervised by the Contractor's RN.

In accordance with the Hawai'i Administrative Rules (HAR) Title 16, Chapter 89 Nurses, Subchapter 15, Delegation of Special Tasks of Nursing Care to Unlicensed Assistive Personnel, all direct care staff who do not possess a medical license must be trained by the agency's RN prior to making medication available to the residents and supervised.

All over-the-counter (OTC) medications must be prescribed for specific residents by the attending physician prior to making the medication available to the youth. The Contractor's RN must be notified of the need to administer the resident-specific OTC medication prior to making the medication available.

## **M. MAINTENANCE OF SERVICE RECORDS**

Both DOE and DOH require that student/youths' records adhere to Federal and State statutes, and accreditation and/or Medicaid standards as applicable. Service records must be current, well-organized, legible, comprehensive and consist of all relevant documentation for the optimum treatment of youth served and coordination of care.

### **DOE: Service Records**

DOE contracted provider agencies must ensure that its employees, agents and volunteers adhere to all applicable state and Federal laws regarding the obtaining and releasing of confidential student information.

The agencies must adopt and implement policies and procedures that govern the provision of services in natural settings and documents that it respects students' and/or families' right to privacy when services are provided in these settings. The DOE shall have the right to inspect and approve these policies.

Provider agency records relating to students under DOE contractual agreements are educational records governed under the Family Educational Rights and Privacy Act (FERPA). The documents and records held by the agency for students serviced under DOE contracts are the property of the DOE. Parental consent for assessment and release of information is covered by the IEP/MP consent. No additional parental consent for assessment or release is needed by the contracted provider agency, its employees, agents and volunteers.

All DOE professionals and contracted providers must maintain master student files, in a central, secure location in locked storage to which access is limited to designated persons in accordance with FERPA regulations.

#### **1. Progress notes**

DOE Progress Notes are the ISPED visit logs and quarterly progress reports. Documentation requirements are further specified in the service-specific standard for each DOE service.

### **CAMHD: Service Records**

CAMHD personnel, contracted agencies, and contracted individual professionals shall have and implement written policies and procedures to guide the content and protocol of youths' records for adherence to Federal law, State statutes, accreditation and Medicaid standards. Service records must be current, well-organized, legible, comprehensive and consisting of all relevant documentation for the optimum treatment of youth served.

Youth full name and/or other identifier, such as CAMHD client registration number, must be on each page of the youth's record. Any adverse drug reactions and/or medication or other allergies or absence of allergies must be posted in a prominent area on the youth's file. Each youth's file contains easily identifiable past and current medical history including serious accidents, surgeries and illnesses. Diagnostic information, medication information, and substance use information are also included. Consultations and special referrals require documentation including resultant reports. Records on children twelve (12) years of age and under include completed immunization record or evidence that immunizations are up to date. Records also contain emergency care rendered with physician follow-up as well as hospital discharge summaries.

Contractors and professionals are required to maintain master client files, including those on youth served by subcontracted providers, in a central, secure location in locked storage to which access is limited to designated persons in accordance with HIPAA regulations. Files in authorized use are also maintained securely.



---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

### 1. Progress Notes

- a. Progress notes are written for each activity/event by the staff/professional providing the service. Every physician contact including medication prescription, administration and monitoring must also be documented. Every therapy session must be documented. Progress notes shall be entered in the youth's file within twenty-four (24) hours of the service/event. Daily progress notes are required for all youth receiving out of home services.
- b. All progress notes must contain the following minimal documentation requirements and must be contained together in a single, continuous note:
  - Complete date of service (including month, day and year)
  - Start and end time of service or start time and duration of service (for non-day rate services);
  - Place of service;
  - Type of service (Individual Therapy, Group Therapy);
  - Either DAP note (Data, Assessment, Plan) or SOAP note (Subjective data, Objective data, Assessment, Plan) format including:
    - Plan of treatment to include objective goals;
    - Diagnostic tests conducted;
    - Treatment and other prescribed regimens;
    - Follow up notes, including results of referrals and subsequent plan of action;
    - Specific time interval for next "visit" or session;
    - Unresolved concerns from previous visit addressed in subsequent visits; and
    - Other health care visits.
  - Full name, title, signature and signature date of service provider; and
  - Full name, title, signature and signature date of supervisor (if applicable).
- c. Electronic medical records are permitted as long as the following criteria are met:
  - A printed copy of the full record must be available in the youth's master file;
  - The electronic record must meet all Medicaid standards;
  - Must contain two (2) client identifiers;
  - Must contain an electronic signature;
  - Must have the date, time and duration of services;
  - Must have description of the service;
  - Must have agency or CAMHD Branch letterhead or heading on each page; and
  - Must be HIPAA compliant.
- d. The focus in the content of notes clearly evidences the relationship of the intervention to the youth's IEP/MHTP/CSP plan. Progress notes need to reference the goals and objectives stated in the youth's treatment plan and include data summaries, the interventions provided and the measurable outcomes resulting from them. Additionally, progress notes need to address what may not be working and what will be done differently for better results.
- e. Progress notes also describe collateral communications pertinent to the treatment of the youth.
- f. Contractors providers shall also electronically submit Monthly Treatment and Progress Summary reports to CAMHD by the 5<sup>th</sup> working day of the following month specifying youth served, service format, service setting, service dates, targets addressed, progress ratings,

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

intervention strategies, projected end date, medications. Outcome measures may also be reported.

### 2. CAMHD Photo

With youth/parent/legal guardian consent, CAMHD Branch must have a current photo (taken within the past 12 months) of the youth in the youth's clinical record.

## N. SERVICE QUALITY

CAMHD and DOE are committed to assuring appropriate and effective services for eligible students/youth and their families. Services are designed to support students/youth in their educational program, promote healthy functioning, increase independence, and to build upon the natural strengths of the student/youth, family/guardian and community. Families/guardians must be active participants in the behavioral support process, given the overwhelming evidence that constructive family participation enhances their student/youth's progress. Interventions are to be evidence-based and tailored to address the identified needs of the student/youth/family. Interventions/plans and progress/outcomes are to be regularly reviewed and modified, as needed, to effectively achieve goals.

Contractors/employees are to participate with the integration of services across domains as needed. Contractors/employees are to assist with transition planning (as it relates to greater and lesser levels of support and services) in collaboration with the student/youth, family/guardian and other team members. DOE and CAMHD encourage individuals with specific concerns regarding service quality to bring them to the attention of the school, provider agency, CAMHD Branch, CAMHD Central Administrative Office, and/or DOE District Office, as appropriate.

CAMHD and DOE Contractors assume all responsibility for the quality of services provided by employees or subcontracted providers. All Contractors shall implement a Quality Assurance and Improvement Program and demonstrate commitment to ongoing quality improvement activities. The quality program must meet Medicaid standards. Contractors must submit quarterly reports of quality monitoring to both CAMHD and DOE.

CAMHD personnel, including MHCCs, Clinical Directors, Certification Specialists, Grievance Specialists, Credentialing Specialists, Program Performance Reviewers and DOE Care Coordinators shall have full access to student/youth and student/youth records while in a CAMHD contracted program.

CAMHD operates a co-planning and co-management model (active involvement and shared decision-making between the CAMHD Branch and Contractors) for any youth that is receiving intensive services, and also conducts regular reviews of child status, treatment practices, and Contractor's performance as part of its accountability and oversight functions.

## O. MINIMUM REPORTING REQUIREMENTS

DOE and CAMHD require submittal of the following reports as determined by the respective department outlined below.

### 1. DOE/CAMHD Credentialing Tracking Form of Licensed Providers:

Contractors are expected to electronically track licensed individual staff and subcontracted professionals and their specific status toward being fully credentialed. This credentialing tracking form spreadsheet includes individuals' active status during the month by name, professional discipline title, appointment date, and termination date. The form is electronically

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

submitted to DOE or CAMHD's Credentialing Specialist (depending upon contracting state agency) by the 15<sup>th</sup> of each month.

### 2. Progress Report

#### **DOE: Progress Report**

- a. Providers (employees and contracted) must complete visit records reflecting all contacts and enter into ISPED (or other designated database) within twenty-four (24) hours.
- b. Medication monitoring providers must complete the DOE specified Psychiatric Medication Monitoring Progress Note after each session. The progress note is placed within the student's agency record, with a copy sent to the IEP/MP care coordinator, within twenty (24) hours of the date of service.
- c. The Student Service Plan shall be turned in to the IEP/MP Care Coordinator within one (1) week of referral, and reviewed and revised, as needed. By the 5<sup>th</sup> of every calendar month, required data must be inputted into ISPED (or other designated database) and the SBBH supplemental database, reporting on the student's end-of-month status, as well as service activities and student progress over the entire month. If the 5<sup>th</sup> falls on the weekend or a holiday, data input is due on the preceding school day.
- d. SBBH Quarterly Progress Reports must address student progress in meeting IEP/MP goals, and shall be completed and made available to the student's IEP/MP Care Coordinator within 2 weeks before the end of the quarter. Also a report is due at the end of the Extended School Year (ESY) period if the student is eligible. Tracking of outcome measures shall, at a minimum, include quarterly completion of the BASC-2 Student Observation System (SOS) in the setting of greatest difficulty. Data shall be incorporated into the SBBH Quarterly Progress Report. The provider shall incorporate the contents of the SBBH quarterly report into the ISPED (or other specified data collection system) quarterly progress report.

#### **CAMHD Progress Report: Monthly Treatment and Progress Summary (MTPS)**

Contractors must electronically submit client-specific monthly treatment and progress summary reports to the appropriate MHCC by the 5<sup>th</sup> day of each month describing the provided service and progress of the youth and family during the preceding month. The report must specify youth served, service format, service setting, service dates, treatment targets, progress ratings, intervention strategies, medications and dosage. Additional outcome measures may also be reported.

The report should be completed by the clinician(s) most familiar with the youth and family's treatment and progress and must be verified for accuracy, signed and dated by a qualified provider. If multiple clinicians within an agency have worked with the youth and family during the month, the clinician completing the MTPS should gather relevant information from others to comprehensively complete the form. The form that must be used for this purpose is the "Service Provider Monthly Treatment and Progress Summary" (See Appendix B-11), and the "Instructions and Codebook for Provider Monthly Summaries" (See Appendix B-12), the most up to date versions can be found at <http://www.hawaii.gov/health/mental-health/camhd/camhd/provider/prov-agency/index.html>. Providers are responsible for on-going training of their clinicians and supervisors in accurate completion of the MTPS. A videotape of the statewide training on the MTPS is available from the CAMHD Clinical Services Office.

### 3. QUALITY ASSURANCE (QA) REPORTS

All Contractors must maintain Quality Assurance Programs, document their Quality Assurance Plan, and submit Quality Assurance Reports.

#### **DOE: QA Report**

##### **a. Quality assurance specifications:**

1. All contracted agencies must participate in, at least annually or frequently quarterly, contract monitoring. This contract monitoring is based on compliance with the DOE monitoring protocol and compliance with all administrative and fiscal aspects of the contract.
2. All documentation and all student records must be made available upon request by the DOE, or for audits scheduled by DOE.
3. All contracted agencies must have a detailed Quality Assurance Plan (QAP). Contracted agencies must implement an internal QAP to assure the delivery of quality educational services, a plan for program assessment, and continuous improvement. The QAP will include evidence supporting their plan and will be available for district/state DOE review.
4. All contracted agencies must participate in District/Complex Quality Assurance Meetings at the request of DOE.
5. All contracted agencies must participate in the Internal Monitoring process at the request of DOE.
6. All providers and agency staff members must adhere to the DOE Guidelines for Water Related Activities. (See Appendix A-14).

##### **b. Output and Performance/Outcome Measurements:**

At a minimum these measures must include:

- Satisfaction of schools and parents with the services;
- Progress and tracking of student outcome measures (at a minimum, to include the quarterly completion of the BASC-2 Observe in the setting of difficulty) related to behavioral and academic achievement;
- Timeliness of services, which includes initiation of services as outlined by the DOE and reports provided by due dates; and
- Services provided are aligned with DOE educational philosophy and complement student's educational curriculum.

##### **c. Service Verification:**

Contracted agencies will also be required to submit prescribed monthly service verification forms documenting that services were actually rendered on the date specified.

##### **d. Sentinel Events and Incidents:**

1. Contracted agencies must submit documentation and evidence of policies and procedures regarding sentinel events and incidents. At a minimum, these policies must address: (1) how the agency will notify the respective school administrator and the appropriate District Education Specialist (DES) within twenty-four (24) hours by fax or

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

phone and in writing within seventy-two (72) hours of any event that compromises the safety of a student utilizing the Sentinel Event / Incident Notification for DOE Contracted Providers form; (2) how the agency tracks the occurrence of all sentinel events and incidents to identify trends and patterns in order to implement improvements; and (3) a complete analysis of the event as well as actions taken to address events.

2. Contracted agencies must submit documentation and evidence of policies and procedures regarding the use of restraints.
3. The Department reserves the right to evaluate the agency's program/service delivery for program monitoring purposes on an annual basis, at a minimum, through either an on-site evaluation or a documentation review.
4. Contracted agencies must submit a SBBH Services FY \_\_\_\_ Final Report at the end of the contract period.

### **CAMHD: Quarterly QA Reports**

Contractors must submit quarterly Quality Assurance Summary reports that are based upon the agency's quality assurance and improvement program that define measurable indicators for identified clinical and non-clinical process and outcome objectives. These reports state the findings and analyses conducted as well as actions that have been or will be taken by the agency following its quarterly review.

Contractors must report the following components, to the CAMHD Performance Management Section every quarter, no later than forty-five (45) days following the end of each quarter. Forty-five days are allowed to give Contractors the time to complete the quarter's data collection and to analyze the data in their quality assurance committee(s). The quarterly Quality Assurance Summary report is to include the following information:

#### **a. Sentinel Events:**

- An analysis, including numbers, types and identified trends and patterns including issues/problems that accounted for the sentinel events.
- Remediation actions and analysis of what accounted for improvement lack of improvement or sustained improvement.

#### **b. Grievances:**

- The number and types of grievances filed in the quarter
- Current status of the grievance investigation (i.e. pending, in process or resolved)
- If resolved, describe the resolution, any operational or administrative changes that were indicated and the status of implementation

#### **c. Staffing / Personnel Activities:**

- Current youth/staff ratios per program component (i.e., per therapist for Intensive In-home; living unit for residential programs)
- Overall adequacy of staff per program including vacancies, overtime patterns, recruiting efforts, analysis of staffing stability per program and availability of clinically qualified professional staff

#### **d. Training and Practice Development:**

- Summary of trainings conducted during the quarter

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

- Reason for the training topic
- Analysis of impact on staff practices

**e. Clinical Supervision:**

- Adherence to supervision requirements, as indicated by the CAMHD supervision standards
- Number of group and individual supervision sessions held during the quarter
- Number and percentage of QMHP's that participated in monthly peer review sessions
- Barriers to meeting one-hundred percent (100%) compliance in supervision practices and related improvement strategies

**f. Credentialing:**

- Percentage of staff credentialed
- Percentage of timely and completed submission of staff files to CAMHD
- Barriers to meeting 100% compliance and related corrective action plan improvement strategies

**g. Clinical Documentation:**

- Completeness, quality and timeliness of clinical records and progress notes based on chart review conducted through a tool that reflects CAMHD requirements. (Note: for sample, see "CAMHD Medical Records Standards" at [www.hawaii.gov/health/mental-health/camhd/provider/prov-agency/index.html](http://www.hawaii.gov/health/mental-health/camhd/provider/prov-agency/index.html))

**h. Performance/Outcome Measures**

1. Access Measures

- Number and percentage of referral acceptance forms sent to the referring CAMHD Branch within two working days
- Number and percentage of youth accepted upon receipt of a complete referral packet
- Number and percentage of youth who began service within fourteen days of referral
- Number and percentage of youth ejected from program

2. Treatment Progress Measure

- Number and percentage of youth that have met 75% of their Mental Health Treatment Plan goals at the time of discharge (Note: This information is derived by CAMHD from the Provider Monthly Summary report)

3. Staff Qualifications Measure

- Number and percentage of staff fully credentialed

4. A form for reporting this data will be provided by CAMHD (See Appendix B-13 & 14). CAMHD will collect the primary source for the measures above and will crosswalk this data with the information provided by contracted provider agencies.

**i. Facility:**

- Status of facility maintenance including cleanliness, needed repairs and safety based upon routine, procedural inspections
- Steps taken to create and sustain a home-like engaging, family-friendly atmosphere
- Facility or administration office re-location plans.

**j. Status of Corrective Action/Improvement Plans:**

- Analysis of performance data used by the agency, and strategies being undertaken to improve and/or sustain performance including evidence of review through the agency's quality committees
- A summary of progress on all corrective actions, improvements and/or required deliverables resulting from CAMHD review of Contractor's performance.
- Summary of procedural and operational changes that have been planned or implemented to address areas that need improvement
- Identification of any barriers to implementing needed improvements and strategies to address barriers.

**k. Contractor Quality Assurance Meeting Agenda and Minutes**

- Submit agendas and minutes for meetings held regarding quality issues conducted during the quarter including summary of any focused reviews and/or special studies planned or conducted.

**4. CAMHD STATE FACILITY LICENSE:**

Contractors shall send a copy of all applicable State facility licenses to CAMHD's Facility Certification Specialist each time facilities are granted licensure and upon renewal of licenses.

**5. CAMHD POLICIES, SCHEDULES, TRAINING CURRICULUM, AND OTHER DOCUMENTS:**

Contractors of Therapeutic Group Homes, Independent Living Program and Community-Based Residential treatment services shall submit, on request, copies of policies, schedules, training curriculum, or other documents as requested by CAMHD's Facilities Certification Specialist.

**6. CAMHD SUMMARY OF LICENSING CORRECTIVE ACTIONS AND ANY REQUIRED DELIVERABLES:**

Applicable Contractors must provide a summary of corrective actions and required deliverables that result from desk or site reviews conducted by CAMHD's Facilities Certification Specialist to Department of Health CAMHD and Office of Health Care Assurance (OHCA).

**7. CAMHD SENTINEL EVENTS:**

All sentinel events, as defined in the CAMHD Sentinel Event Policy and Procedure 80.805 (See Appendix B-16), shall notify the youth's parent/legal guardian and MHCC within twenty-four (24) hours of occurrence by fax or phone and submit a written hard copy report on the CAMHD 72-Hour Sentinel Event Report Form (See Appendix B-17) submitted to CAMHD Sentinel Events Specialist and the CAMHD Branch within three (3) working days of the event. Working days exclude weekends and state holidays.

**8. CAMHD ACCREDITATION:**

Current Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Council on Accreditation of Rehabilitation Facilities (CARF), or Council on Accreditation (COA) is required. All Contractors shall submit evidence of current accreditation to CAMHD Performance Management Section.

**9. CAMHD WEEKLY CENSUS REPORT ON CLIENT STATUS AND WAITLISTED YOUTH**

All out-of home levels of care including Therapeutic Foster Homes, Multidimensional Treatment Foster Care, Therapeutic Group Homes, Community-Based Residential Programs, Independent Living Programs, Acute Psychiatric Hospitalization, and Hospital-Based Residential treatment

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

service are required to submit a CAMHD Weekly Census Report on Client Status Form. (See Appendix B-19) in standard format to CAMHD's Clinical Services Office, Utilization Management section no later than Tuesday noon of each week either by fax or electronically.

### **10. CAMHD ATTENDANCE AND ENCOUNTER RECORDS:**

Attendance records and encounter records must be maintained at each facility for prescribed program activities. Residential facilities must maintain a log of whole day and/or night absences from both program and residence whether authorized or not. Such records are filed in the youth's file and made available to CAMHD upon request. All Contractors with an educational component must submit the CAMHD Education Attendance Report (See Appendix B-21) to the CAMHD Fiscal section in a format and schedule to be specified by CAMHD.

### **11. CAMHD TITLE IV-E ADMINISTRATIVE REPORTS:**

In accordance with CAMHD's efforts to maximize federal reimbursement, quarterly submission of Title IV-E Training Activity and Cost Reports (See Appendix B-22) by applicable Contractors to the CAMHD Fiscal Section is required, using standard training reporting forms.

### **12. Other specified reports/documents periodically requested by the CAMHD.**

CAMHD may periodically request specific information or documents to address specific issues or system needs. In making these requests CAMHD will be sensitive to the anticipated resources required of contractors to respond to such requests. Nevertheless, contractors are expected to provide such information upon request by CAMHD.

## **P. RISK MANAGEMENT**

All CAMHD/DOE Contractors must have policies and procedures that address critical risk management activities that include the following:

### **1. Criminal, Child Abuse, and Background Screening**

#### **DOE: Screening**

DOE contracted provider agencies shall make all reasonable investigations to determine whether a prospective employee, employee, agent, or volunteer has been convicted of any criminal offense pursuant to any law enforcement or military authority which would make the prospective employee, employee, agent or volunteer unsuited for working in close proximity to children. Furthermore, the contracted provider agency shall inform the DOE if any prospective employee, employee, agent or volunteer who is providing services under DOE contract has been convicted of a criminal offense. The DOE reserves the right to refuse the services of any prospective employee, employee, agent or volunteer of the PROVIDER.

DOE contracted provider agencies shall require, at a minimum, local criminal history checks on all employees, agents, and volunteers including, but not limited to administrative and program staff members who work in close proximity to children. Fingerprinting checks required under DOE contracts shall be completed before any employee, agent and volunteer of the PROVIDER is assigned to any work site. Upon express statutory authority for the DOE to conduct national criminal history checks on contracted providers, a national criminal history check shall be required.

All costs associated with the conducting and processing of the criminal history checks of all DOE contracted provider agencies' employees, agents, and volunteers shall be the responsibility of the contracted provider agency.



The contracted provider agency shall maintain a record of the mandatory criminal history checks performed on each of its employees, agents, and volunteers. Additionally, the agency shall maintain and update a list of all new employees, agents, and volunteers that document the status and completion dates of the mandatory criminal history checks and other primary source verification.

The DOE reserves the right to monitor the contracted provider agency's compliance on an annual basis, at a minimum, through either an on-site evaluation or a documentation review.

### **CAMHD: Screening**

CAMHD requires a background check on each employee that has direct contact with children and youth receiving contracted services. This includes a Criminal History Record Check through the Hawai'i Criminal Justice Data Center and Hawai'i Child Protective Services System, a Child Abuse and Neglect screening in accordance with CAMHD P&P 80.406 "Child Abuse and Neglect Check: (See Appendix B-23), a driver's license screening, and references from all employers for the previous three (3) years of employment. Annually a Child Abuse and Neglect screening must be conducted. Every two (2) years a local criminal records check must be conducted. This is documented in the employee's personnel file. The Contracting agency is responsible for reviewing the documentation and taking actions as needed.

## **2. Safety**

DOE/CAMHD require Contractors to have procedures to insure the safety and well being of student/youth at all times. Safety is relative to known risks, and is not an absolute protection from all possible risks.

Contractors shall manage, control, or alter potentially harmful conditions, situations, or operations including those leading to abuse, neglect and sexual exploitation, or induced by student/youth's high-risk behaviors to prevent or reduce the probability of physical or psychological injuries to student/youth.

Safety from harm extends to freedom from unreasonable intimidation and fears that may be induced by other children, line staff, treatment professionals, or others.

Safety applies to settings in the natural community as well as to any special care or treatment setting.

## **3. Restraints and Seclusion**

The State of Hawai'i is committed to fostering violence-free and coercion-free treatment environments for children and adolescents. As part of this commitment, CAMHD advocates that Contractors seek to minimize the use of restraint and seclusion, and work to increase the effective use of positive behavioral support strategies. Restraint and seclusion are emergency interventions that are used only to assure safety in situations where there is imminent risk of physical harm. Each student/youth has a right to be free from restraint or seclusion in any form that is used as a means of coercion, discipline, convenience, or retaliation.

Historically, seclusion and restraint have been seen as a necessary and even therapeutic part of treatment for those with emotional and behavioral difficulties. Over the past two (2) decades, however, there has been an increasing recognition nationally that: 1) restraint and seclusion can lead to student/youth injury and even death and 2) student/youth usually experience significant psychological trauma in the course of seclusion or restraint interventions, and 3) treatment

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

environments that minimize use of these methods are safer for both student/youth and staff members.

Because incidents of restraint and seclusion represent a significant risk to student/youth and staff members, the DOE, CAMHD and all Contractors shall have internal policies and procedures regarding Restraints and Seclusion. The policies and procedures must include, but are not limited to, the following:

- The training that staff must receive prior to using restraint or seclusion with an emphasis on the serious potential for restraint or seclusion to cause injury or death;
- Reviewing and updating restraint and seclusion policies and procedures regularly, based on clinical outcomes;
- Agency-wide priority to use restraint or seclusion only when there is no safe alternative to prevent harm to self or others, safely and in accordance the agency's restraint and seclusion policies and procedures;
- Adequate allocation of resources to prevent the frequent use of restraint or seclusion; and
- Appropriate decision-making guidelines for when the use of restraint or seclusion is necessary.

Non-aversive interventions and positive behavioral supports shall be the *absolute first course of action* to ensure the safety of the student/youth and others. These strategies must be part of a programmatic youth-specific plan to anticipate and manage a high-risk situations and unsafe behavior, and it must be clearly documented that such non-aversive strategies were the first course of action.

Restraint or seclusion are safety interventions *of last resort* and are to be used only in situations where risk of danger to the student/youth or others is reasonably imminent. Any use of seclusion or restraint must be documented and tracked following the use of the most recent and current Centers for Medicare and Medicaid Services accreditation standards.

**Seclusion** involves maintaining a student/youth in a locked and/or secure room to ensure the safety of the student/youth or others. Any such isolation in a secure environment from which the student/youth is not potentially free to leave is considered seclusion (e.g., having a staff member block the exit from an unlocked seclusion room). The use of seclusion as a safety intervention is different from the use of the discipline technique called a "time out". Time out from reinforcement is the removal of a student/youth from potentially rewarding people or situations. A "time out" is not used primarily to confine the student/youth, but to limit accessibility of reinforcement. Such a time-out requires constant monitoring by staff. In a time out, the individual is not physically prevented from leaving the designated time-out area.

**Mechanical restraint** involves restricting a student/youth's movement through the use of a restraining device (e.g., four point bed restraints) to ensure the safety of the student/youth or others.

**Physical restraint** involves any use of physical force to restrict a student/youth's freedom of movement. Physical escorts in which the student/youth is willfully cooperating with the guide are not considered restraint until such time as the student/youth no longer intends to follow or be escorted (e.g., student/youth struggles with staff).

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

**Chemical restraint** involves the incidental use of medications and drugs to control unsafe behavior through temporary sedation or other related pharmacological action. Adjusting the dose of a prescribed medication or prescribing a new medication to achieve better symptom control is not considered chemical restraint.

Restraints and seclusions are treated as potentially dangerous emergency procedures.

Restraint and seclusion:

- Are not to be used as treatment interventions.
- Require: a) written orders, b) on-going monitoring during the intervention, c) assessment of the student/youth when the intervention is concluded, d) debriefing of staff and student/youth involved, and e) notification of the student/youth's guardians and CAMHD.
- Must terminate when the emergency safety situation has ended and the risk of imminent harm has passed, even if the order has not expired.
- Shall not be used simultaneously.
- May not exceed four (4) hours for 18-21 year olds, two (2) hours for 9-17 year olds, and one (1) hour for children less than nine (9) years of age.
- Must not involve the use of mouth coverings.
- Must not result in harm or injury to the student/youth.
- Standing orders and as-needed (PRN) orders are prohibited.

### Orders:

Chemical restraints must be preceded by a written order by a qualified physician. That physician must be available to staff for consultation, at least by telephone, throughout the entire period of the emergency safety intervention.

Other forms of restraint and seclusion may be ordered only by: a) a board-certified psychiatrist, b) a licensed psychologist, or c) a physician licensed to practice medicine with specialized training and experience in the diagnosis and treatment of mental diseases.

Such orders utilize the least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based on consultation with staff. Standing orders and as needed (PRN) orders are prohibited. Safety interventions must not involve the use of mouth coverings nor result in harm or injury to the student/youth.

Each order must include:

- The name and signature of the staff issuing the order;
- The date and time the order was issued; and
- The type of emergency safety intervention ordered, including the length of time authorized.

The qualified person issuing the order must be available to staff for consultation, at least by telephone, throughout the period of the emergency safety intervention.

If the emergency safety situation continues beyond the time limit of the order for the use of restraint or seclusion, a registered nurse or other licensed professional, such as a licensed practical nurse, must immediately contact the person who issued the order to receive further instructions.

### **Monitoring**

Clinical staff, trained in the use of emergency safety interventions, must be physically present, continually assessing and monitoring the physical and psychological well being of the student/youth and the safe use of restraint throughout the entire duration of the emergency safety intervention.

Clinical staff, trained in the use of emergency safety interventions, must be physically present in or immediately outside of the seclusion room, continually assessing, monitoring, and evaluating the physical and psychological well being of the youth in seclusion. Video monitoring does not meet this requirement. The seclusion room must:

- Allow staff full view of the student/youth in all areas of the room; and
- Be free of potentially hazardous conditions such as unprotected light fixtures and electrical outlets.

### **Assessment after the initial intervention**

For Hospital-Based Facilities: A board-certified psychiatrist, licensed psychologist, or physician licensed to practice medicine with specialized training and experience in the diagnosis and treatment of mental diseases who issued the order must conduct a *face-to-face assessment* of the student/youth's well being *within one (1) hour of the initiation of the emergency safety intervention*.

**For Non-Hospital-Based Programs:** If the authorized individual who issued the order is not available, Centers for Medicare and Medicaid Services (CMS) regulations require a clinically qualified registered nurse trained in the use of emergency safety interventions to conduct a *face-to-face assessment* of the student/youth's well being *within one (1) hour of the initiation of the emergency safety intervention*.

### **All assessments will include, but are not limited to:**

- The student/youth's physical and psychological status;
- The student/youth's behavior;
- The appropriateness of the intervention measures as a last resort, safely applied, monitored, released ASAP and return to preventative milieu; and
- Any complications resulting from the intervention (e.g. trauma or injury).

### **Notification**

The program must notify the parent(s) or legal guardian(s) that the student/youth has been restrained or placed in seclusion as soon as possible after the initiation of each emergency safety intervention. Documentation of this notification, including the date and time of notification and the name of the staff person providing the notification, will be placed in the student/youth's master file. The program must document attempts to establish contact within twenty-four (24) hours of initiation of the restraint or seclusion.

Each Contractor must record, maintain, and track, any use of seclusion and restraint following the most recent and current Centers for Medicare and Medicaid Services accreditation standards. At minimum, information shall include:

- The type of restraint or seclusion used;
- Staff involved;
- Documentation of the verbal and/or written order;
- Witnesses to the restraint/seclusion;
- The time frame and duration of use;

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

- The rationale for restraint or seclusion;
- The types of less restrictive alternatives that were tried or considered; and
- An assessment of the student/youth's adjustment during the episode and reintegration to the daily program.

A sentinel event telephone call must be made to CAMHD within twenty-four (24) hours of the occurrence of the restraint or seclusion. Complete written documentation of the episode must follow to the CAMHD within seventy-two (72) hours (three working days) of the sentinel event via a the Sentinel Event Report form, including (1) a review of the less restrictive alternatives that were considered, and (2) a reference to the debriefing with the youth and all staff and residents who were involved in or witnessed the event.

### **Debriefing**

As soon as possible, but at least within twenty-four (24) hours after the use of restraint or seclusion, the student/youth and all staff (except when the presence of a particular staff person may jeopardize the well-being of the resident) involved in the emergency safety intervention must have a face-to-face discussion.

Other staff and the parents or legal guardians may participate when it is deemed appropriate by the facility. If this occurs the program must conduct such a discussion in a language that is understood by the parents or legal guardians.

The discussion must provide both the student/youth and staff the opportunity to discuss the circumstances leading to the use of restraint or seclusion and strategies to be used by the staff, the student/youth, or others that could prevent the future use of restraint or seclusion.

Within twenty-four (24) hours after the use of restraint or seclusion, all staff involved in the emergency safety intervention, and appropriate supervisory and administrative staff, must conduct a debriefing session. A senior manager not involved in the event should lead the debriefing session. This formal debriefing must include, at a minimum, a review and discussion of:

The emergency safety situation that required the intervention, including a discussion of the setting events and *precipitating factors* (e.g. identification of the behavior being controlled) that led up to the intervention;

Alternative techniques and client de-escalation preferences that were implemented or might have prevented the use of the restraint or seclusion;

The procedures, if any, that staff are to implement to prevent any recurrence of the use of restraint or seclusion;

The outcome of the intervention, including any injuries that may have resulted from the use of restraint or seclusion;

Determination of whether imminent danger was present and whether the early signs of risk were detected;

The procedures for notification, documentation, and return to the therapeutic environment.

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

The agency must document in the student/youth's record that *both* debriefing sessions took place and must include the names of staff who were present for the debriefing, names of staff who were excused, and any changes to the student/youth's treatment plan that resulted from the debriefings.

### 4. Sentinel Events and Incidents

All CAMHD Contractors must have internal policies and procedures regarding sentinel events and incidents in accordance with CAMHD's P&P 80.805 "Sentinel Events/Incidents" attachment "Sentinel Event Code Definitions" (See Appendix B 18). At a minimum these policies must address:

- How the Contractor notifies CAMHD (CAMHD Branch and Sentinel Events Specialist) or DOE within twenty-four (24) hours by fax or telephone and in writing within seventy-two (72) hours (excluding week ends and state holidays) of any serious sentinel event as defined in CAMHD's P&P 80.805";
- How the Contractor tracks the occurrence of all incidents and sentinel events to identify trends and patterns in order to implement improvements; and
- A complete analysis of the event as well as actions taken to address the event. Both the initial notification and the subsequent written report must be forwarded to the CAMHD Performance Management-Section and the MHCC, or applicable DOE school administrator and district educational specialist (depending upon contracting state agency involved).

QMHP's shall review all events reported by staff as evidenced by their signature to the Sentinel Events Report form, in discerning whether the events are reportable incidents in accordance with CAMHD's definitions.

### 5. Police

Requests for police assistance should be limited to situations where the student/youth's behavior is deemed to be critically out of control and can no longer be safely contained by staff. CAMHD's out of home providers are to follow their internal crisis management procedures including consultation with their QMHP prior to requesting police assistance.

## Q. STUDENT / YOUTH RIGHTS AND CONFIDENTIALITY

CAMHD and DOE recognize the rights of all students/youth and families accessing behavioral health services.

### DOE: Consumer Rights

All DOE employees and contracted agencies and their employees or subcontracted professionals are required to recognize the rights of students and families as safeguarded under IDEA 2004 and HAR 8-56 and the Section 504 of the Rehabilitation Act and HAR 8-53.

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

### **CAMHD: Consumer Rights**

All Contractors and their employees or subcontracted professionals are required to recognize CAMHD Consumer Rights and Responsibilities that state:

- You have the right to be treated with respect. You also have the right to your privacy.
- You have the right to treatment no matter what your situation is. You have this right regardless of your: age, race, sex, religion, culture, ability to communicate, or disability.
- You have the right to know about the CAMHD, the services you can receive and who will provide the services. You also have the right to know what your treatment and service choices are.
- You have the right to know all of your rights and responsibilities.
- You have the right to get help from CAMHD in understanding your services.
- You are free to use your rights. Your services will not be changed or you will not be treated differently if you use your rights.
- You have the right to receive information and services in a timely way.
- You have the right to be a part of all choices about your treatment. You have the right to have your treatment plan in writing.
- You have the right to disagree with your treatment or to ask for changes in your treatment plan.
- You also have the right to ask for a different provider. If you want a different provider, we will work with you to find another provider in our network.
- You have the right to refuse treatment.
- You have the right to get services in a way that respects your culture and what you believe in.
- You have the right to look at your records and add your opinion when you disagree. You can ask for and get a copy of your records. You have the right to expect that your information will be kept private within the law.
- You have the right to complain about your services and to expect that no one will try to get back at you. If you complain, your services will not stop unless you want them to.
- You have the right to be free from being restrained or secluded unless an allowed doctor or psychologist approves, and then only to protect you or others from harm. Seclusions and restraints can never be used to punish you or to keep you quiet. They can never be used to make you do something you don't want to do. They can never be used to get back at you for something you have done.

All employees and Contractors must adhere to these rights in the provision of behavioral health services to eligible youth. Each Contractor is to identify a Behavioral Health Rights Advisor within their organization who will ensure that all youth and families are made aware of their rights, and that the provider respects and upholds these rights.

Each Contractor shall have in place, its own administrative process through which youth and their families can have their concerns and/or complaints addressed in a thorough and efficient manner. MHCC reviews the CAMHD Consumer Handbook with parents and youth (as appropriate) who sign a form acknowledging receipt of this information as well as the Notice of Privacy Practices. The Acknowledgement Form is filed in the youth's chart.

### **R. COMMUNITY FOCUS**

DOE and CAMHD shall participate in local community organizations, including service areas boards, neighborhood boards and/or Community Children's Councils (CCC). DOE and CAMHD shall work collaboratively with the community organizations to address issues and concerns about the services and the continuum of care provided to Hawai'i's eligible student/youth. Contractors are required to participate in local community organizations to ensure healthy, ongoing communication between the providers and the community organizations and to provide opportunities for collaboration in the development of behavior health services/resources to complement existing services and to meet local needs.

### **S. TEAM-BASED DECISIONS**

All behavioral health services with the exception of emergent and urgent services are the result of team-based decisions and are driven by the student/youth and family/guardian. The IEP/MP/CSP team utilizes assessment information evidenced-based service information, practice guidelines and performance standards to make decisions. Services emanate from an IEP/MP, or CSP with a BSP/SSP or MHTP to elaborate the program and setting specific actions.

### **T. GRIEVANCES/APPEALS**

DOE and CAMHD respect the right of any student/youth or family to disagree with aspects of planning or service delivery and will make every effort to resolve these disagreements directly with the family. If resolution is not possible in direct exchange, families and providers have additional recourse through the DOE Due Process Administrative Hearing Avenue, or CAMHD's Grievances and Appeals Process (See Appendix B-25 Grievance and Grievance Appeals P&P 80.603). Student/youth and/or families are informed of these processes at their school-based team meetings, and upon registration at a CAMHD Branch. If a service is going to be denied, terminated or reduced, CAMHD provides at least ten (10) days notice to the youth/family and Contractor (if applicable). This notice includes appeal rights and appeal process information.

### **U. ACCOUNTABILITY/SERVICE STANDARDS**

All Contractor will remain obligated to (a) aspects of the contract as agreed upon by DOE, CAMHD, and the provider; (b) to general professional practice and ethical standards as dictated by the various State professional and vocational licensing standards; (c) to general standards of practice as described by the evidenced-based services committee; (d) and to service standards as delineated in this manual.

DOE and CAMHD shall be responsible for monitoring each contract at least annually and more frequently as needed.

### **V. CAMHD BED HOLDS AND THERAPEUTIC PASSES**

#### **1. Bed Holds**

Whenever a youth is absent from an out of home program for twenty-four (24) hours, due to elopement or placement in Acute Psychiatric Hospitalization, Community Hospital Crisis Stabilization, Community-based Crisis Group Home, Detention Home or Hawaii Youth Correctional Facility, CAMHD may authorize a hold the bed for up to seven (7) consecutive days at fifty percent (50%) of the unit rate. The Contractor must accept the youth back into the



program at anytime during the bed hold period, unless it has been determines, at the cost of the Contractor, through an evaluation by a CAMHD approved independent psychiatrist that an alternate service is necessary. The results of this evaluation must be provided to CAMHD in writing prior to any action being taken. If the youth returns after seven (7) days, the Contractor is obligated to accept the return of the youth if there are any vacant beds. If there are no vacant beds, the Contractor is obligated to put the youth on the waitlist with an anticipated admission date. CAMHD reserves the right to execute contractual action if the Contractor is unable or unwilling to meet the needs of the youth.

### **2. Therapeutic Passes**

A therapeutic passed is defined as a pass of twenty-four (24) hours to assist the youth/young adult in achieving their MHTP goals. Therapeutic passes are used to assist youth in maintaining/improving family relationships, generalizing skills to the home/community and transitioning to home/community living. Therapeutic passes are planned and require prior approval by the MHCC, except for unplanned family emergencies. Therapeutic passes are paid at one hundred percent (100%) of the contacted rate up to the number of days specified in the service-specific standard. Therapeutic passes beyond the threshold are reimbursed at fifty percent (50%) of the contracted rate. Passes of less than twenty-four (24) hours do not require prior authorization and are not considered “therapeutic passes.” The thresholds, for therapeutic passes are included in the “Clinical Operations” section of each eligible out-of-home service-specific standard.

***SECTION II:***

**SERVICE SPECIFIC PERFORMANCE STANDARDS**

***SECTION II – PART A:***

**EMERGENCY MENTAL HEALTH  
PERFORMANCE STANDARDS**

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

### SECTION II – PART A: EMERGENCY MENTAL HEALTH PERFORMANCE STANDARDS

#### I. EMERGENCY MENTAL HEALTH SERVICES:

##### A. 24-HOUR CRISIS TELEPHONE STABILIZATION

<b>Definition</b>	24-Hour Crisis Telephone Stabilization serves all youth whose immediate health and safety may be in jeopardy due to a mental health issue. After receiving support, consultation and referral that dissipate the crisis situation, the youth's natural environment has the capacity to allow the youth to remain safely in the community. The absence of this capacity would indicate need for mobile outreach services to assess situation and arrange appropriate course of actions.
<b>Services Offered</b>	<ol style="list-style-type: none"><li>1. Crisis Telephone Stabilization services is staffed twenty-four (24) hours/seven (7) days a week.</li><li>2. Initial assessment is made over the phone regarding the nature of the mental health crisis.</li><li>3. Support, consultation and referral services are provided based on the initial assessment.</li><li>4. The crisis worker provides the caller with sufficient information or guidance to dissipate crisis.</li><li>5. The agency must provide at least quarterly advertisements of the 24-Hour Crisis Telephone Stabilization service via public service announcements, flyers, posters, mailing list, etc.</li></ol>
<b>Admission Criteria</b>	All youth, families or community members in need of help during a crisis.
<b>Initial Authorizations</b>	No authorization needed.
<b>Discharge Criteria</b>	Crisis situation diffused and natural supports sufficient for youth to remain safe in the community or dispatch of Crisis Mobile Outreach team.
<b>Service Exclusions</b>	No exclusions.
<b>Clinical Exclusions</b>	No exclusions.

#### Staffing Requirements:

In addition to the staffing requirement listed in the general standards, these staff requirements must also be followed. If the standards referenced here differ from those in the general standards, these staffing requirements will supersede the general standards.

1. A QMHP is on call twenty-four (24) hours a day, seven (7) days a week, in the event of clinical or complex psychiatric related situations in need of consultation and is available for on-call service, consultation, direction, and case debriefings.
2. The agency staff must under the supervision of a QMHP. A MHP with crisis experience must be on the premises at a minimum of eight (8) hours/day and must be on call at all other times.
3. The agency must have adequate numbers of crisis workers available, particularly during peak call hours to minimize call waiting and call hold instances.
4. At a minimum, crisis workers must meet paraprofessional credentialing requirements.

### Clinical Operations

1. Services are available twenty-four (24) hours a day, seven (7) days a week.
2. Trained crisis workers must be available at all times to assess the nature and severity of the mental health crisis, provide needed support and consultation, and refer for appropriate treatment or other needed service.
3. The crisis telephone stabilization service must be a toll free number for all callers in the covered geographic area.
4. Crisis telephone stabilization service must have Telephone Device for the Deaf (TTY) or Text Telephone Display (TTD) capacity.
5. All calls must be answered by trained crisis workers within three (3) rings or ten (10) seconds.
6. All calls must not be on hold for more than fifteen (15) seconds.
7. The agency must have a process for dispatching crisis telephone stabilization calls for on-site visits by the mobile outreach team when situations warrant face-to-face lethality assessments and consultation.
8. The agency must have protocols to ensure that crisis workers have timely access to the agency's QMHP for assistance with complex situations. Protocols must specify the role of the QMHP in providing additional guidance until the crisis dissipates or diminishes, or until the mobile outreach team arrives and initiates services.
9. Prior to performing hotline services, hotline workers receive at least twenty-four (24) hours of orientation training including: crisis assessment and intervention, suicidal assessment, homicidal assessment, clinical protocol, proper documentation, and knowledge of community resources.
10. Hotline workers must be familiar with CAMHD service array and other community resources and services to provide guidance and referrals to callers.
11. The program must have documented training on a quarterly basis, to expand knowledge base and skills relative to crisis intervention treatment protocols as guided by the agency's training curriculum, and youth-specific situations experienced by crisis telephone stabilization workers. Training should promote Evidence-Based Services and Best Practice procedures for urgent and emergent care situations.
12. Please see Section I General Standards for additional clinical operation requirements:
  - H. Staffing
    - Orientation and Training and Training Requirements for CAMHD Contactors;
  - I. Supervision
  - J. Evaluation of Staff Performance;
  - K. Credentialing Requirements;
  - P. Risk Management

### Documentation

1. An emergency service note must be completed and entered in the service log immediately, that includes, to the extent provided by the caller:
  - a. Identifying demographic information.
  - b. The date and actual time and duration of the services rendered.
  - c. The worker who took the call.
  - d. The nature of the crisis.
  - e. Description of the nature of interventions made, including natural community resources utilized in diminishing the crisis and ensuring the safety of the youth.
  - f. The involvement of additional staff in the provision of service, particularly the on-call QMHP or MHP.
  - g. The youth's status, referrals for continued services and disposition at the end of the call.

## **INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES**

---

- h. If the youth's name is not given, a note describing any relevant general information (e.g. male teenager) is obtained. Anonymous caller notes are placed in a separate file.
  - i. Contact with any current providers or reference to current treatment or crisis plans in place for the youth.
- 2. If the youth is registered with a CAMHD Branch, this documentation must be forwarded to the MHCC by closure of the next business day.
- 3. The crisis telephone stabilization agency must have the necessary systems in place to monitor calls, length of calls, call wait times and aborted calls. These reports must be provided to CAMHD every quarter.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### B. CRISIS MOBILE OUTREACH

<b>Definition</b>	This service provides mobile outreach assessment and stabilization services face-to-face for youth in an active state of psychiatric crisis. Services are provided twenty-four (24) hours per day, seven (7) days per week and can occur in a variety of settings including the youth's home, local emergency facilities, and other related settings. Immediate response is provided to conduct a thorough assessment of risk, mental status, and medical stability, and immediate crisis resolution/stabilization and de-escalation if necessary.
<b>Services Offered</b>	<ol style="list-style-type: none"> <li>1. Twenty-four (24) hour-seven (7) day a week response.</li> <li>2. Immediate response is required, with a maximum arrival time within forty-five (45) minutes of notification.</li> <li>3. Pre-hospitalization screening and assessment.</li> <li>4. Crisis intervention and counseling.</li> <li>5. Intensive in-home services to stabilize the family.</li> <li>6. Arrangement of and assist with transportation to a Community Based Crisis Group Home, Community Hospital Crisis Stabilization, or Emergency Room (when needed).</li> <li>7. Care coordination, including obtaining information regarding any involved providers/agencies involved with youth and notifying the involved parties about the crisis the next business day.</li> <li>8. Care coordination also includes arranging appropriate referrals to community resources or at a minimum providing family with community resource cards for youth not currently receiving behavioral health services.</li> </ol>
<b>Admission Criteria</b>	<p>At least <u>one</u> (1) of the following criteria is met:</p> <ol style="list-style-type: none"> <li>1. The youth may be a danger to self or others;</li> <li>2. The youth may be displaying acute psychotic symptoms such as delusions, hallucinations, and thought disorganization that are unmanageable; or</li> <li>3. The youth evidences lack of judgment, impulse control, or cognitive/perceptual abilities.</li> </ol>
<b>Initial Authorizations</b>	<p>Prior procurement is not required for this level of care. Usual time frame is one (1) to four (4) hours.</p> <p>Unit = fifteen (15) minutes</p>
<b>Discharge Criteria</b>	<p>At least <u>one</u> (1) of the following criteria is met:</p> <ol style="list-style-type: none"> <li>1. Appropriate community or natural resources are planned and/or engaged to reduce stress factors and to stabilize the current living environment and the youth's symptoms/behaviors abate to a level no longer requiring outreach services;</li> <li>2. The youth is admitted to Community Based Crisis Group Home or Community Hospital Crisis Stabilization service because the situation could not be stabilized in the home; or</li> <li>3. The youth is escorted to a hospital-based emergency unit for medical disposition.</li> </ol>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

<b>Service Exclusions</b>	None
<b>Clinical Exclusions</b>	None

### Staffing Requirements:

In addition to the staffing requirement listed in the general standards, these staff requirements must also be followed. If the standards referenced here differ from those in the general standards, these staffing requirements will supersede the general standards.

1. The program must be under the supervision of a QMHP. This QMHP must be available for service and treatment consultation, direction, facilitation or field visits as necessary.
  2. Psychiatric services must be available twenty-four (24) hours/seven (7) days a week.
  3. At a minimum, mobile outreach staff must be:
    - a. A Paraprofessional with a Bachelor's degree either in Social Work, Psychology, Counseling, or Nursing working under the guidance of a MHP, with two (2) years supervised clinical experience in providing direct crisis response for youth.
- OR**
- b. A MHP with one (1) year supervised clinical experience in providing direct crisis response for youth.
4. There are no specific face-to-face ratios, however pairs of staff may be needed where the safety of workers is of concern or where more than one staff is needed to successfully defuse the situation.

### Clinical Operations

In addition to the clinical operation requirements listed in the general standards, these requirements must also be followed. If the standards referenced here differ from those in the general standards, these clinical operation requirements will supersede the general standards.

1. Services are available twenty-four (24) hours a day, seven (7) days a week.
2. Staff respond and are on site within forty-five (45) minutes of the initial phone call.
3. For more remote or small geographic locations such as Hana or Ka'u, face-to-face assessments by the staff shall occur within the usual transport time to reach that destination if staff is not stationed at the remote site. However, the program must make, with the approval of their QMHP, alternative interim arrangements sufficient to ensure the safety of the youth until the mobile outreach worker arrives.
4. Assessment and therapeutic stabilization/resolution and/or disposition of the youth in crisis are timely, appropriate, and effective. Families/caregiver(s) and other involved providers/agencies, if not already involved, are sought and informed by the next business day.
5. If the youth is registered with a Branch, the crisis worker contacts the MHCC at the time of the crisis or leaves a telephone message for the MHCC with a full report of the occurrences, including any requirements for MHCC follow-up. Information exchange guides the collaboration process toward stabilization/resolution and disposition and follow through of services.
6. The youth and family are provided information about, and as necessary, linked to appropriate medical, social, mental health, or other community resources or at minimum provided with a community resources card with contact information for accessing the resources.
7. Prior to arranging for emergency room assessments the staff shall seek consultation of the agency's on-call psychiatrist. The psychiatrist may either make a field visit for a face-to-face evaluation and possible emergency treatment, or contact the emergency unit with significant information in anticipation of the youth's arrival, or conduct a face-to-face evaluation at the emergency unit. The agency's psychiatrist will direct the staff regarding additional actions to make or preparations to take.



---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

8. Staff are expected to remain with the youth at any emergency unit until the youth is either admitted, transported, or released.
9. If the crisis worker believes emergency services are needed, then the worker will contact the program's on call Psychiatrist for consultation. If the Psychiatrist determines that Community Based Crisis Group Home or Community Hospital Crisis Stabilization are needed, the Psychiatrist will notify the appropriate service of the forthcoming admit.
10. The agency must make a follow-up call to the family within twenty-four (24) hours of the mobile crisis intervention to ensure that the crisis has stabilized and referral sources (if needed) were contacted and document the results.
11. Staff must have at least twenty-four (24) hours of orientation training including: crisis field assessment and intervention, self-harm and suicide assessment, clinical protocols, documentation, knowledge of community resources as well as the court processes and legal documents relative to emergency procedures, and specific legal issues governing informed consents that must be completed prior to performing crisis outreach services. Training should promote Evidenced-Based Services and Best Practice procedures for urgent and emergent situations.
12. The program must have documented ongoing training on a quarterly scheduled basis, to expand knowledge base and skills relative to crisis intervention and treatment protocols as guided by the agency's training curriculum, and youth-specific situations experienced by emergency workers.
13. Please see Section I General Standards for specific clinical operation requirements regarding:
  - G. CAMHD Continuity of Care;
  - H. Staffing:
    - Orientation and Training and Training Requirements for CAMHD Contactors;
  - I. Supervision;
  - J. Evaluation of Staff Performance;
  - K. Credentialing Requirements;
  - N. Service Quality;
  - O. Minimum Reporting Requirements;
  - P. Risk Management:
    - Criminal, Child Abuse, and Background Screening;
    - Safety;
    - Restraints and Seclusion;
    - Police;
    - Sentinel Events and Incidents.

### Documentation

In addition to the documentation requirements listed in the general standards, these requirements must also be followed. If the standards referenced here differ from those in the general standards, these documentation requirements will supersede the general standards.

1. Clinical documentation must be recorded and include all significant written information available, including, but not limited to: the nature and status of the crisis; demographic information; signed parental consents to transport youth; or ex-parte applications and authorizations. All such documentation must be prepared and arranged in advance of the youth's arrival at any emergency unit.
2. An outreach service note must be documented for each youth. The note must include all of the following:
  - a. Identifying information: youth name, date of birth (DOB), address, phone number, legal guardian, school/home-school, and grade;
  - b. The place, date and actual time (start and end time) and duration of services rendered;
  - c. The outreach service worker rendering the service;

## **INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES**

---

- d. Description of the nature of the crisis;
  - e. Description of the nature of interventions made, including natural community resources utilized in diminishing the crisis and ensuring the safety of the youth;
  - f. The involvement of additional staff in the provision of service, particularly the on-call QMHP;
  - g. The youth's status, referrals for continued services and disposition at closure of the outreach services;
  - h. Specific follow-through recommendations, including the need for additional services; and
  - i. Documentation of follow-up phone call to the family twenty-four (24)-hours later with date and time of call and follow-up results;
- 3. A copy of this note is sent to the MHCC by closure of the next business day if the youth is registered with a Branch.
  - 4. A brief written summary accompanies the youth to the Crisis Therapeutic Foster Home, Community Based Crisis Group Home or Community Hospital Crisis Stabilization placement and consists of information that facilitates assessment, communication, continued stabilization and disposition of the youth.
  - 5. A copy of the note documenting the results of the agency follow-up call to the family is sent to the MHCC by the closure of the next business day after the follow-up call, if the youth is registered with a Branch.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### C. CRISIS THERAPEUTIC FOSTER HOME

<b>Definition</b>	This service offers short-term, acute interventions to youth experiencing mental health crises in a Therapeutic Foster Home. This is a structured alternative to, or diversion from, Acute Psychiatric Hospitalization or Community Hospital Crisis Stabilization. Crisis stabilization services are for youth who are experiencing a period of acute stress that significantly impairs their capacity to cope with normal life circumstances and who cannot be safely managed in a less restrictive setting. The home provides psychiatric services that address the psychiatric, psychological, and behavioral health stabilization needs of the youth.
<b>Services Offered</b>	<ol style="list-style-type: none"> <li>1. Services are available twenty-four (24) hours, seven (7) days a week;</li> <li>2. Services are provided in a twenty-four (24) hour supervised Therapeutic Foster Home setting;</li> <li>3. Crisis intervention stabilization and counseling for youth and family;</li> <li>4. Family based interventions;</li> <li>5. Psychiatric evaluation and medication management services are provided;</li> <li>6. Skills development directed at improving the youth's ability to cope with daily stressors; manage emotions and behaviors; improve communication and strengthen interpersonal relationships;</li> <li>7. Services are provided to assist youth and families to find and secure necessary community supports and to communicate and collaborate with relevant community members, or with the IEP/CSP team as applicable.</li> </ol>
<b>Admission Criteria</b>	<p>At least <u>one</u> (1) of the following criteria is met:</p> <ol style="list-style-type: none"> <li>1. The youth may be a danger to self or others, expressing suicidal ideation or is engaging in self-destructive or self-mutilating behaviors;</li> <li>2. The youth may be displaying psychotic symptoms such as delusions, hallucinations, and thought disorganization; or</li> <li>3. The youth evidences lack of judgment, impulse control, or cognitive/perceptual abilities.</li> <li>4.</li> </ol>
<b>Initial Authorizations</b>	Days 1-3 require no prior authorization. Youth may be admitted via Mobile Crisis Outreach or via CAMHD Clinical Directors with parental consent.
<b>Re-Authorization</b>	<p>Days 4-7 [maximum of four (4) additional days] require prior authorization from Branch in the youth's home district.</p> <p>Unit = one (1) day.</p>
<b>Continuing Stay Criteria</b>	<p>At least <u>one</u> (1) of the following criteria is met:</p> <ol style="list-style-type: none"> <li>1. The youth continues to be a danger to self or others;</li> <li>2. The youth continues to display acute psychotic symptoms</li> </ol>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	such as delusions, hallucinations, and thought disorganization; or 3. The youth continues to lack judgment, impulse control, or cognitive/perceptual abilities.
<b>Discharge Criteria</b>	At least <u>one</u> (1) of the following criteria is met: 1. The youth's targeted symptoms and/or behaviors have abated and can be managed in his/her natural environment with the necessary support services; 2. The youth's psychological, social and/or physiological levels of functioning have returned to a level that allows the youth's safe return to his/her natural environment with the necessary support services; or 3. Appropriate natural community resources have been mobilized or are planned to reduce stress factors and to stabilize the current living environment.
<b>Service Exclusions</b>	Not offered at the same time as Hospital-Based Residential, Acute Psychiatric Hospitalization or Community Hospital Crisis Stabilization.
<b>Clinical Exclusions</b>	Youth with the following conditions are excluded from admission: Moderate to Severe Mental Retardation.

### Staffing Requirements:

In addition to the staffing requirement listed in the general standards, these staff requirements must also be followed. If the standards referenced here differ from those in the general standards, these staffing requirements will supersede the general standards.

1. Foster parent must be licensed with the Department of Human Services prior to service initiation.
2. The foster parent must be under the supervision of a QMHP with experience in providing crisis interventions to youth and families.
3. A QMHP must oversee the treatment services for the crisis therapeutic foster home.
4. If indicated as needed by the program's QMHP, safety watches require a parent to youth ratio of one to one (1:1).
5. The Contractor ensures the provision of necessary additional personnel, to meet the needs of the youth receiving services for emergencies including escorts and remaining with the youth at an emergency unit, or maintaining one to one (1:1) supervision of a youth.
6. A licensed psychiatrist must be available twenty-four (24) hours, seven (7) days a week for assessment and medication as needed. The psychiatrist must have staff privileges at the nearest community hospital. The psychiatrist arranges for coverage in his or her absence. The person who is covering must be Hawaii licensed and ABPN board certified in child and adolescent psychiatry and able to assist (including face-to-face assessments) as necessary.

### Clinical Operations

In addition to the clinical operation requirements listed in the general standards, these requirements must also be followed. If the standards referenced here differ from those in the general standards, these clinical operation requirements will supersede the general standards.

1. Services are available twenty-four (24) hours a day, seven (7) days a week.

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

2. The program is required to have a psychiatrist or psychologist provide twenty-four (24) hour on-call coverage, seven (7) days a week.
3. The foster home will have no more than two (2) minor youth in the home and no more than two (2) foster youth in placement with them, unless a waiver is requested and approved by CAMHD for a sibling group placed together. There shall be a minimum of one (1) adult at home whenever a youth is present. The agency shall ensure additional staff support as necessary.
4. Youth must be in line of site supervision of foster parent at all times during awake hours.
5. During sleeping hours, foster parent ensures the youth's presence and safety through minimally quarter-hour visual checks during the youth's first four (4) hours following admission or when not in line of site supervision. Quarter-hour visual checks may be waived if crisis mobile outreach assessment and crisis foster home assessment clinically justify the absence of lethal or elopement factors and this is duly documented and signed by the qualified professional making the assessment.
6. The physical structure of living premises shall, to the extent possible, prevent the youth's elopement during sleep hours between visual check intervals.
7. In conjunction with the anticipated short duration of stay, youths' education is not considered a primary focus. However, transition planning shall consider youths' educational needs such that loss of academic credits is minimized.
8. All efforts are made to ensure the assessment, stabilization, and treatment efforts continue to be family centered in accordance with CASSP. Family members and naturalistic supports are included in all aspects of planning.
9. There is daily communication between the crisis foster agency, the IEP/CSP team, and the family, through the MHCC if the youth is registered with CAMHD, to keep everyone apprised of the youth's status and progress.
10. The crisis foster home agency has medical emergency information, plans, and mechanisms to ensure appropriate and timely medical emergency interventions.
11. Severe crisis occurrences at the home must result in a call for consultation with the agency's psychiatrist. The existence of medical indications, including the possibility of hospitalization, requires the psychiatrist to conduct a face-to-face assessment with the youth and caregiver(s) and provide necessary guidance and treatment either at the home or at a hospital emergency unit. The psychiatrist will contact a hospital to which he or she has staff privileges to facilitate arrangements for an evaluation at the hospital emergency unit if it seems indicated that the youth might need Acute Psychiatric Hospitalization or Community Hospital Crisis Stabilization care.
12. Assessment and therapeutic resolution and/or disposition of the youth in crisis are timely, appropriate, and effective. Parent(s)/caregiver(s), involved agencies/providers, if not already involved, are immediately sought and informed when located.
13. The Contractor shall have written policies and procedures and train foster parents on securing and storing medications; labeling and administering medications as ordered by a physician; recording medication administration, youth request for adjustment or change, and any side effects and notifying physician or advanced practice registered nurse immediately of possible side effects; and disposing of medications.
14. Contact with the MHCC should occur at the time of admission to the crisis foster home and daily contact with the MHCC is maintained, if the youth is registered with CAMHD.
15. If indicated, referrals of non-IDEA youth are initiated for DOE identification and eligibility procedures or referred to CAMHD for SEBD eligibility.
16. Follow-up services for non-IDEA or non-SEBD youth are arranged through the families' medical insurance or community resources.
17. Foster families are required to receive at least two (2) hours a month of supervision from the Contractor's QMHP. One (1) hour of the required, supervision may be multi-family or group supervision.

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

18. Staff must have at least twenty-four (24) hours of orientation training including: crisis field assessment and intervention, suicide/self-harm assessment, clinical protocols, proper documentation, knowledge of community resources as well as knowledge of the court processes and legal documents relative to emergency procedures and specific legal issues governing informed consents that must be completed prior to initiating services.
19. The program must also have documented training on a quarterly scheduled basis, to expand knowledge base and skills relative to crisis intervention and treatment protocols as guided by the Contractor's training curriculum, and youth-specific situations experienced by foster parents. Trainings specific to the effects of seclusions and restraint, and alternatives to emergency safety interventions are required on a quarterly basis. These training count toward the twenty (20) hours of training required annually for therapeutic foster families. Documentation of all training is the responsibility of the Contractor.
20. At contract award and biannually thereafter, all Contractors of Therapeutic Foster Homes Services shall submit a list of foster families with all of the following information required on the Therapeutic Foster Home Profile Form (See Appendix B-15). Biannually, or if necessary, upon CAMHD request, the Contractors shall update this report and submit any changes to the CAMHD Clinical Services Office, Utilization Management Section that shall maintain the information in accordance with all confidentiality requirements.
21. Please see Section I General Standards for additional requirements clinical operation requirements:
  - G. CAMHD Continuity of Care;
  - H. Staffing;
  - I. Supervision;
  - J. Evaluation of Staff Performance;
  - K. Credentialing Requirements;
  - L. Medication Monitoring / Tracking;
  - N. Service Quality;
  - O. Minimum Reporting Requirements;
  - P. Risk Management:
    - Criminal, Child Abuse, and Background Screening;
    - Safety;
    - Restraints and Seclusion;
    - Sentinel Events and Incidents;
    - Police.

### Documentation

In addition to the documentation requirements listed in the general standards, these requirements must also be followed. If the standards referenced here differ from those in the general standards, these documentation requirements will supersede the general standards.

1. If a crisis plan does not exist, the crisis foster home's QMHP shall formulate the crisis plan and transition plan from the program.
2. The crisis foster parents shall actively participate in crisis treatment planning processes and communicate daily with the family and involved agencies.
3. Crisis plans shall be detailed, specific to each youth's needs incorporating positive behavioral supports and youth de-escalation preferences, including to whom, when and how information is conveyed, and actions to be implemented.
4. Clinical documentation must be recorded and include all significant information available, including, but not limited to: the nature and status of the crisis; psychiatric and other medications the youth is taking if any, demographic information; signed parental consents to transport, evaluate and treat at emergency units, and to hospitalize as applicable; and ex-parte

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

applications as applicable, all of which must be prepared and arranged in advance of any youth's arrival at any emergency unit.

5. A brief written discharge summary shall accompany the youth to another level of care and/or school consisting of information that facilitates assessment, communication, ongoing intervention and disposition of the youth with appropriate consent for release of information.
6. Provide parents with information about how to refer to DOE as applicable for a comprehensive evaluation to determine IDEA eligibility.
7. Provide parents with information about how to refer to CAMHD as applicable for Support for Emotional and Behavioral Development (SEBD) program eligibility.
8. The QMHP's progress notes shall reflect clinical observations and progress and therapeutic interventions with a specific focus on both the youth as well as the parent(s)/caregiver(s).
9. Therapeutic Foster Parents shall maintain progress notes that provide a) daily attendance log indicating the youth's presence or absence from the home including absences of twenty-four (24) hours or more and b) provide daily progress notes as documentation of treatment progress, events or activities youth engaged in and developmental milestones achieved. These notes shall be fully dated and signed by the foster parent, originals of which shall be placed in the agency's master youth file within seven (7) calendar days. These foster home progress notes may be in the form of a checklist or written note.
10. Please see Section I General Standards for additional documentation requirements:
  - E. Service Planning
    - Mental Health Treatment Plan including transition, crisis and discharge planning;
    - Discharge Summary;
  - M. Maintenance of Service Records;

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### D. COMMUNITY-BASED CRISIS GROUP HOME

<b>Definition</b>	This service offers short-term, acute residential interventions to youth experiencing mental health crises. This is a structured residential alternative to, or diversion from, Acute Psychiatric Hospitalization or Community Hospital Crisis Stabilization. Crisis stabilization services are for youth who are experiencing a period of acute stress that significantly impairs their capacity to cope with normal life circumstances and who cannot be safely managed in a less restrictive setting. The program provides psychiatric services that address the psychiatric, psychological, and behavioral health stabilization needs of the youth.
<b>Services Offered</b>	<ol style="list-style-type: none"> <li>1. Services are available twenty-four (24) hours, seven (7) days a week;</li> <li>2. Services are provided in a twenty-four (24) hour supervised residential setting;</li> <li>3. Crisis intervention stabilization and counseling for youth and family;</li> <li>4. Family based interventions;</li> <li>5. Psychiatric evaluation and medication management services are provided;</li> <li>6. Skills development directed at improving the youth's ability to cope with daily stressors; manage emotions and behaviors; improve communication and strengthen interpersonal relationships;</li> <li>7. Services are provided to assist youth and families to find and secure necessary community supports and to communicate and collaborate with relevant community members, or with the IEP/CSP team as applicable.</li> </ol>
<b>Admission Criteria</b>	<p>At least <u>one</u> (1) of the following criteria is met:</p> <ol style="list-style-type: none"> <li>1. Youth is between twelve (12) and eighteen (18) years of age;</li> <li>2. The youth may be a danger to self or others, expressing suicidal ideation or is engaging in self-destructive or self-mutilating behaviors;</li> <li>3. The youth may be displaying psychotic symptoms such as delusions, hallucinations, and thought disorganization;</li> <li>4. The youth evidences lack of judgment, impulse control, or cognitive/perceptual abilities.</li> </ol>
<b>Initial Authorizations</b>	Days 1-3 require no prior authorization. Youth may be admitted via Mobile Crisis Outreach or via CAMHD Clinical Directors with parental consent.
<b>Re-Authorization</b>	<p>Days 4-7 [maximum of four (4) additional days] require prior authorization from Branch in the youth's home district.</p> <p>Unit = one (1) day</p>
<b>Continuing Stay Criteria</b>	At least <u>one</u> (1) of the following criteria is met:



## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<ol style="list-style-type: none"><li>1. The youth continues to be a danger to self or others;</li><li>2. The youth continues to display acute psychotic symptoms such as delusions, hallucinations, and thought disorganization; or</li><li>3. The youth continues to lack judgment, impulse control, or cognitive/perceptual abilities.</li></ol>
<b>Discharge Criteria</b>	At least <u>one</u> (1) of the following criteria is met: <ol style="list-style-type: none"><li>1. The youth's targeted symptoms and/or behaviors have abated and can be managed in his/her natural environment with the necessary support services;</li><li>2. The youth's psychological, social and/or physiological levels of functioning have returned to a level that allows the youth's safe return to his/her natural environment with the necessary support services; or</li><li>3. Appropriate natural community resources have been mobilized or are planned to reduce stress factors and to stabilize the current living environment.</li></ol>
<b>Service Exclusions</b>	Not offered at the same time as Hospital-Based Residential, Acute Psychiatric Hospitalization or Community Hospital Crisis Stabilization.
<b>Clinical Exclusions</b>	Youth with the following conditions are excluded from admission: Moderate to Severe Mental Retardation;

### Staffing Requirements:

In addition to the staffing requirement listed in the general standards, these staff requirements must also be followed. If the standards referenced here differ from those in the general standards, these staffing requirements will supersede the general standards.

1. Staff supervision is provided on a twenty-four (24) hours, seven (7) days a week basis.
2. The program staff must be under the supervision of a QMHP with experience in providing crisis interventions to youth and families.
3. At minimum, two (2) direct care staff shall be on duty per shift in each living unit, with one (1) staff awake during overnight shifts
4. A ratio of not less than one (1) staff to four (4) youth is maintained at all times.
5. If indicated as needed by the program's QMHP, safety watches require a staff ratio of one to one (1:1).
6. A licensed psychiatrist must be available twenty-four (24) hours, seven (7) days a week. The psychiatrist must have staff privileges at the nearest community hospital. The psychiatrist arranges for coverage in his or her absence. The person who is covering must be Hawaii licensed and ABPN board certified in child and adolescent psychiatry and able to assist (including face-to-face assessments) as necessary.
7. A licensed registered nurse is on staff or on contract to establish the system of operation for administering or supervising youth's medication and medical needs or requirements, monitoring the youth's response to medications, and training staff to administer medication and proper protocols.
8. A QMHP must oversee the treatment services for community based crisis group home.
9. The Contractor ensures the provision of necessary additional personnel, to meet the needs of the youth receiving services for emergencies including escorting and remaining with the youth at an emergency unit, or maintaining one to one (1:1) supervision of a youth.

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

10. At a minimum, staff must be:
  - a. A Paraprofessional with two (2) years supervised clinical experience in providing direct crisis response for youth.
  - OR**
  - b. A MHP with one (1) year supervised clinical experience in providing direct crisis response for youth.
  - AND**
  - c. A licensed registered nurse is on staff or on contract to establish the system of operation for administering or supervising youth's medication and medical needs or requirements, monitoring the youth's response to medications, and training staff to administer medication and proper protocols.

### Clinical Operations

In addition to the clinical operation requirements listed in the general standards, these requirements must also be followed. If the standards referenced here differ from those in the general standards, these clinical operation requirements will supersede the general standards.

1. Services are available twenty-four (24) hours a day, seven (7) days a week.
2. A ratio of not less than one (1) staff to four (4) youth is maintained at all times, however there is a minimum requirement of two (2) staff on duty at all times.
3. At least one (1) staff member per shift is required to have a current CPR and First Aid certification.
4. Youth must be in line of site supervision of staff at all times during awake hours.
5. During sleeping hours, program ensures the youth's presence and safety through minimally quarter-hour visual checks during the youth's first four (4) hours following admission or when not in line of site supervision of staff. Quarter-hour visual checks may be waived if crisis mobile outreach assessment and community based crisis group home assessment clinically justify the absence of lethal or elopement factors and this is duly documented and signed by the qualified professional making the assessment.
6. The physical structure of group living premises shall, to the extent possible, prevent the youth's elopement during sleep hours between visual check intervals.
7. In conjunction with the anticipated short duration of stay, youths' education is not considered a primary focus. However, transition planning shall consider youths' educational needs such that loss of academic credits is minimized.
8. All efforts are made to ensure the assessment, stabilization, and treatment efforts continue to be family centered in accordance with CASSP. Family members and naturalistic supports are included in all aspects of planning.
9. There is daily communication between the program, the IEP/CSP team, and the family, through the MHCC if the youth is registered with CAMHD, to keep everyone apprised of the youth's status and progress.
10. The Contractor shall have written policies and procedures and train staff on securing and storing medications; labeling and administering medications as ordered by a physician; recording medication administration, youth request for adjustment or change, and any side effects and notifying physician or advanced practice registered nurse immediately of possible side effects; and disposing of medications.
11. The Program has medical emergency information, plans, and mechanisms to ensure appropriate and timely medical emergency interventions.
12. Severe crisis occurrences at the home must result in a call for consultation with the Contractor's psychiatrist. The existence of medical indications, including the possibility of hospitalization, requires the psychiatrist to conduct a face-to-face assessment with the youth and caregiver(s) and provide necessary guidance and treatment either at the home or at a hospital emergency unit. The psychiatrist will contact a hospital to which he or she has staff privileges to facilitate

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

- arrangements for an evaluation at the hospital emergency unit if it seems indicated that the youth might need Acute Psychiatric Hospitalization or Community Hospital Crisis Stabilization care.
13. Assessment and therapeutic resolution and/or disposition of the youth in crisis are timely, appropriate, and effective. Parent(s)/caregiver(s), involved agencies/providers, if not already involved, are immediately sought and informed when located.
  14. The crisis worker contacts the MHCC at the time of admission to the community based crisis group home and maintains daily contact with the MHCC, if the youth is registered with CAMHD.
  15. If indicated, referrals of non-IDEA youth are initiated for DOE identification and eligibility procedures or referred to CAMHD for SEBD eligibility.
  16. Follow-up services for non-IDEA or non-SEBD youth are arranged through the families' medical insurance or community resources.
  17. Staff must have at least twenty-four (24) hours of orientation training including: crisis field assessment and intervention, suicide/self-harm assessment, clinical protocols, proper documentation, knowledge of community resources as well as knowledge of the court processes and legal documents relative to emergency procedures and specific legal issues governing informed consents that must be completed prior to initiating services.
  18. The program must also have documented training on a quarterly scheduled basis, to expand knowledge base and skills relative to crisis intervention and treatment protocols as guided by the agency's training curriculum, and youth-specific situations experienced by crisis workers. Trainings specific to the effects of seclusions and restraint, and alternatives to emergency safety interventions are required on a quarterly basis.
  19. Please see Section I General Standards for additional clinical operation requirements:
    - G. CAMHD Continuity of Care;
    - H. Staffing;
    - I. Supervision;
    - J. Evaluation of Staff Performance;
    - K. Credentialing Requirements;
    - L. Medication Monitoring / Tracking;
    - N. Service Quality;
    - O. Minimum Reporting Requirements;
    - P. Risk Management:
      - Criminal, Child Abuse, and Background Screening;
      - Safety;
      - Restraints and Seclusion;
      - Sentinel Events and Incidents;
      - Police.

### Documentation

In addition to the documentation requirements listed in the general standards, these requirements must also be followed. If the standards referenced here differ from those in the general standards, these documentation requirements will supersede the general standards.

1. If a crisis plan does not exist, the Contractor's MHP shall formulate the crisis plan and transition plan from the program.
2. The Contractor's staff shall actively participate in crisis treatment planning processes and communicate daily with the family and involved agencies.
3. Crisis plans shall be detailed, specific to each youth's needs incorporating positive behavioral supports and youth de-escalation preferences, including to whom, when and how information is conveyed, and actions to be implemented.
4. Clinical documentation must be recorded and include all significant information available, including, but not limited to: the nature and status of the crisis; demographic information; signed

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

parental consents to transport, evaluate and treat at emergency units, and to hospitalize as applicable; and ex-parte applications as applicable, all of which must be prepared and arranged in advance of any youth's arrival at any emergency unit.

5. A brief written discharge summary shall accompany the youth to another level of care and/or school consisting of information that facilitates assessment, communication, ongoing intervention and disposition of the youth with appropriate consent for release of information.
6. Provide parents with information about how to refer to DOE as applicable for a comprehensive evaluation to determine IDEA eligibility.
7. Provide parents with information about how to refer to CAMHD as applicable for Support for Emotional and Behavioral Development (SEBD) program eligibility.
8. Individual staff's shift notes shall reflect the treatment plan and youth's status in adjusting to the new environment through observations and interventions.
9. The MHP's daily progress notes shall reflect clinical observations and progress and therapeutic interventions with a specific focus on both the youth as well as the parent(s)/caregiver(s).
10. Please see Section I General Standards for additional documentation requirements regarding:
  - E. Service Planning
    - Mental Health Treatment Plan including transition, crisis and discharge planning;
    - Discharge Summary;
  - M. Maintenance of Service Records;
    - Progress Notes



***SECTION II – PART B:***

**SCHOOL - BASED  
BEHAVIORAL HEALTH SERVICES  
PERFORMANCE STANDARDS**

### Introduction

The DOE School Based Behavioral Health (SBBH) Program is embedded in the Department's Comprehensive Student Support System (CSSS) and is consistent and compliant with the requirements of the Individuals with Disabilities Education Act (IDEA) and Section 504 of the Rehabilitation Act. The DOE's CSSS is designed to serve all school students and involves school-wide prevention, early intervention, and intensive services for students with significant emotional and/or behavioral needs. Student support is provided by a variety of professionals, including Teachers, Counselors, Social Workers, Behavioral Specialists, and Psychologists, across the five levels of student support.

The structure of SBBH relies on the application of best practices for identifying and addressing problem behaviors that interfere with the student's learning. In keeping with Hawaii Child and Adolescent Service System Principles (CASSP), the least restrictive and least intrusive interventions are implemented first to address problem behaviors. Students with disabilities (IDEA and 504) who require highly intensive and complex behavior supports are provided those services by the DOE's SBBH Program, in partnership with the DOH CAMHD system of service delivery. The SBBH Program focuses on the promotion of social and emotional development and the use of school based and broader community resources to support students (and their families) in becoming successful learners and community members. The determination of which specific interventions to use is based on a sequence of evidence based information gathering, planning and implementation activities including families, communities and behavior support professionals and support staff.

SBBH services delineated in this document are delivered in accordance with an Individualized Education Program (IEP) or a Modification Plan (MP) based upon decisions of the team. DOE services are provided by DOE personnel; DOE contracted services are utilized when necessary.

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

### SECTION II – PART B: SCHOOL - BASED BEHAVIORAL HEALTH SERVICES PERFORMANCE STANDARDS

#### I. SCHOOL - BASED BEHAVIORAL HEALTH SERVICES

##### A. FUNCTIONAL BEHAVIORAL ASSESSMENTS AND BEHAVIORAL SUPPORT PLANS

<b>Service Description</b>	<p>Functional Behavioral Assessment (FBA) is a process that provides a framework for developing effective programs for students. It examines the events that reliably predict and maintain problem behavior while using a strength-based approach that considers the “whole child” and the context in which the behavior occurs. It addresses problem behavior by developing behavior support plans that move away from being reactive and punitive in nature, to plans that are proactive with research-validated practices. The approach is geared at utilizing a student’s strengths to provide a basis for plan development, instructional programming, and behavior management that are geared to each individual’s needs, preferences, and long-term goals.</p> <p>(Refer to Functional Behavior Assessment (FBA) and Behavior Support Plan (BSP) Guide and related tools in Appendix A 6-13.)</p>
<b>Services Offered</b>	<p>Functional Behavioral Assessment and Behavioral Support Plans includes all of the following:</p> <ol style="list-style-type: none"><li>1. Contact the school and family and arrange appointment(s) with the school staff, student and family within one week of referral.</li><li>2. Conduct the FBA within two weeks of referral.<ol style="list-style-type: none"><li>a. Parental consent for FBA and release of information is covered by the IEP/MP consent. No additional parental consent for FBA or release is needed by the assessor or contracted provider.</li></ol></li><li>3. Complete written report and resultant Behavior Support Plan (BSP), a sample of which is in the Appendix A 8 -9, within 30-days of referral and submit to the IEP/MP Care Coordinator.</li><li>4. The written report shall include all of the following:<ol style="list-style-type: none"><li>a. Broad information: (this type of information can be gathered from various places including team discussions, interviews, review of records, rating scales, specific skill assessments).<ol style="list-style-type: none"><li>i. Student’s strengths and skill limitations;</li><li>ii. Daily routines and activities;</li><li>iii. Identifications of positive and negative consequences;</li><li>iv. Health concerns;</li><li>v. Quality of life indicators (relationships, choice and control, access to reinforcing activities);</li></ol></li><li>b. Specific information: (this type of information can be gathered from various forms of informant and observation techniques including the Behavior</li></ol></li></ol>



## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p>Assessment System for Children, 2<sup>nd</sup> Edition BASC-2), team discussions, scatter plots, and Antecedent Behavior Consequences (ABC) analyses. The assessor must consider the BASC-2 data/reports and incorporate them in the evaluation/recommendations.</p> <ol style="list-style-type: none"> <li>i. Student's strengths and skill limitations;</li> <li>ii. Daily routines and activities;</li> <li>iii. Identifications of positive and negative consequences;</li> <li>iv. Health concerns;</li> <li>v. Quality of life indicators (relationships, choice and control, access to reinforcing activities);</li> <li>vi. Baseline data;</li> <li>vii. Specific events or factors that contribute to the student's problem behavior;</li> <li>viii. When the student is most likely to engage in the problem behavior;</li> <li>ix. What appears to be maintaining the student's behavior;</li> <li>x. What function(s) the problem behavior serves for the student;</li> <li>xi. When the student is less likely to engage in problem behavior (Identify characteristics of these situations); and</li> <li>xii. Factors that might be contributing to the student's problem behavior.</li> </ol> <ol style="list-style-type: none"> <li>5. Once the assessment process is completed and predictable patterns emerge that explain when and why the student is engaging in problem behavior, the assessor shall develop a hypothesis statement. The hypothesis will serve as a foundation on which to design a behavior support plan and should include the following:             <ol style="list-style-type: none"> <li>a. When this happens (a description of specific antecedents associated with the problem behavior);</li> <li>b. The student does this (a description of the problem behavior); and</li> <li>c. In order to (a description of the possible function of the behavior).</li> </ol> </li> <li>6. Clear hypothesis statements should lead to interventions that are based on understanding the functions of the student's behavior. BSPs shall be detailed and contain the following elements:             <ol style="list-style-type: none"> <li>a. Antecedent and setting event modifications;</li> <li>b. Teaching of alternative skills using research based practice;</li> <li>c. Consequence strategies to strengthen alternative skills, reduce the pay off for the problem behavior, and crisis prevention/intervention;</li> <li>d. Lifestyle interventions that include long-term maintenance of skills;</li> <li>e. Implementation date of the Behavior Support Plan;</li> </ol> </li> </ol>
--	--

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<ul style="list-style-type: none"> <li>f. Delineation of who is responsible for each intervention;</li> <li>g. Criteria to evaluate progress; and</li> <li>h. Crisis management plan, if needed.</li> </ul> <p>7. Assessor will submit the FBA and BSP, utilizing DOE prescribed process, checklist and tools. (See Appendix A 6-13.)</p>
<b>Referral Criteria</b>	<ul style="list-style-type: none"> <li>1. DOE Standards of Practice (SOP) (Appendix A-5b) have been followed, and</li> <li>2. A school-level FBA process has been conducted and BSP implemented, and</li> <li>3. An SST/IEP or MP Team determines the student requires further assessment to determine strengths, behavioral health needs and recommendations as part of the Chapter 56 or Chapter 53 process.</li> </ul>
<b>Authorization</b>	<p>DOE Standards of Practice (SOP) (Appendix A-5b) have been followed, and if procured, Procurement Procedures (PP) have been followed.</p> <p>If required as part of the Chapter 56 or Chapter 53 process and an FBA is procured, prior authorization via a completed DOE procurement work order is required for each assessment. The procured flat rate reflects the time required for completing the data gathering, assessment process, behavioral support plan, feedback session, and final report. There is no payment for travel time, wait time, appointment no-shows, or cancellations.</p> <p>Event is only billable upon completion of the FBA/BSP report and must be submitted to the IEP/MP Care Coordinator before submitting an invoice claim and before payment will be made.</p> <p>Maximum Billable: Flat rate per FBA/BSP is required.</p>
<b>Completion of Service</b>	<ul style="list-style-type: none"> <li>1. The assessment and feedback session have been completed; and</li> <li>2. The written assessment report and resultant Behavior Support Plan meet standards, as described, and are submitted within 30-days of referral to the IEP/MP Care Coordinator. Assessments not meeting these standards will be returned to the assessor for correction. Payment may not be made or a reimbursement will be sought if assessments are not corrected according to prescribed standards.</li> <li>3. If required as part of the Chapter 56 or Chapter 53 process and an FBA is conducted, assessors are required to input assessment and data information in the ISPED (or other designated database) modules that the DOE requires, within the timeframe required by the DOE.</li> </ul>

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

### Staffing Requirements:

Assessors must meet one of the following requirements:

1. DOE personnel with training and experience in the FBA and plan development in an educational setting to facilitate a team of staff knowledgeable about the student.  
**OR**
2. Hawaii licensed psychologist or psychiatrist **AND** have a minimum of one (1) year of supervised training in child and adolescent assessment.  
**OR**
3. Individual who possesses a Master's degree, doctoral degree, or is a doctoral candidate in a graduate program in psychology or psychiatry from a regionally or nationally accredited program **AND** has a minimum of one (1) year of documented training and supervised experience in the FBA and plan development within an educational setting **AND** works under the supervision of a licensed psychologist or psychiatrist meeting standards above. **[NOTE:** At a minimum, the supervisor must review all prior reports/data; review all current assessment data; and participate in the interpretation of data, and the development of a diagnoses and recommendations. The supervisor is to sign the report acknowledging responsibility for the assessment.  
**OR**
4. Master's level classified, certified, or licensed behavior support and educational staff **AND** has a minimum of three (3) years of documented training and supervised experience in the FBA and plan development within an educational setting.

### Service Operations

1. Parent(s), student, and staff associated with the behavior support plan are actively involved in the process.
2. Plan contains all required service content components.
3. Plan is typed.
4. Plan is submitted and meets timelines.
5. Plan is proactive and is strength-based.
6. Plan addresses a student's needs and does not specify a particular program or eligibility status
7. Assessment of student progress in plan objectives yields a clear picture of plan effectiveness.
8. Report includes original signature(s) of the assessor (and supervisor as necessary) acknowledging responsibility for the assessment.

### Documentation:

Assessors are required to input information in the ISPED (Integrated Special Education Database) or other designated database modules that the DOE requires, within the timeframe required by the DOE.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### B. EMOTIONAL BEHAVIORAL ASSESSMENTS- COMPREHENSIVE

<b>Service Description</b>	Diagnostic and evaluation service involving a strengths-based approach to identify student's needs in the context of school, family and community. This service includes completion of an initial comprehensive assessment as part of the DOE identification and eligibility process. Service components include written assessment, recommendations supported by empirical research, and a feedback session of the assessment results.
<b>Services Offered</b>	<p>An Emotional Behavioral Comprehensive Assessment ( "EBA Comprehensive"), includes <u>all</u> of the following:</p> <ol style="list-style-type: none"> <li>1. Contact the school and family and arrange appointment(s) with the school staff, student and family within one week of referral.</li> <li>2. Conduct the assessment within two weeks of referral: <ol style="list-style-type: none"> <li>a. Parental consent for assessment and release of information is covered by the IEP/MP consent. No additional parental consent for assessment or release is needed by the assessor.</li> <li>b. Review and incorporate DOE evaluation reports, including psychometric test results, if available.</li> <li>c. Review and incorporate any other relevant data including developmental, psycho-social, medical, educational, and legal histories as provided by the school student services coordinator (SSC).</li> <li>d. Interview school personnel -- teachers, counselors, and/or administrators, or other persons that have first-hand knowledge of the functioning of the student.</li> <li>e. Interview family/significant others.</li> <li>f. Interview student face-to-face.</li> <li>g. Administer assessment instruments as indicated to include a minimum the BASC-2, CALOCUS, CAFAS and Achenbach checklists from home (CBCL) and school (TRF) and youth (YSR), if 11 years or older.</li> </ol> </li> <li>3. Submit the written report within 30 days of referral to the IEP/MP Care Coordinator. A written report includes <u>all</u> of the following: <ol style="list-style-type: none"> <li>a. Date(s) of assessment and date of report.</li> <li>b. Identifying information: student name, DOB, legal guardian, home-school, grade, IDEA/504 status.</li> <li>c. Reason(s) for referral.</li> <li>d. Sources of information: including review of records, interviews, and assessment tools.</li> <li>e. Brief developmental, medical, family, social educational, and psychiatric history-include post and current use of and reasons for psychotropic medications.</li> <li>f. Substance use history.</li> <li>g. Description and history of presenting problems(s).</li> <li>h. Behavioral observations and Mental Status Exam must include <u>all</u> of the following:</li> </ol> </li> </ol>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<ul style="list-style-type: none"> <li>i. Appearance, attitude, and behavior;</li> <li>ii. Orientation;</li> <li>iii. Affect and mood;</li> <li>iv. Thought content/processes: <ul style="list-style-type: none"> <li>1. Fund of knowledge;</li> <li>2. Intelligence;</li> <li>3. Cognitive processes and</li> <li>4. Memory;</li> <li>5. Insight;</li> <li>6. Judgment; and</li> <li>7. Homicidal/suicidal risk.</li> </ul> </li> <li>i. Assessment Results and interpretation, which must include specific scores, plotted profiles, and analytical interpretations of the BASC-2, CALOCUS, CAFAS and Achenbach Checklists. The school will provide the BASC-2 data in the referral packet. This shall include a copy of the protocols, the scores, and the printed reports. The assessor must consider the BASC-2 data/reports and incorporate them in the evaluation/recommendations.</li> <li>j. Student and Family Strengths.</li> <li>k. Clinical Formulation/Justification of Diagnoses (include severity and duration of diagnoses; for Rule/Out or Provisional diagnoses, explain what needs to occur to obtain a more definite diagnosis).</li> <li>l. Diagnostic Impression: DSM IV-5 Axes.</li> <li>m. The written report shall address a student's needs and shall not specify a particular service, program, provider, or eligibility status. The IEP/MP Team determines whether a student needs a fully self-contained class, residential placement, at-home instruction, etc. All recommendations shall be supported by empirical research.</li> <li>n. Provider information including signature, name and degree(s) of the evaluator, and the position and name of institution/organization of the evaluator is affiliated (if indicated and appropriate).</li> </ul>
<b>Referral Criteria</b>	<p>DOE Standards of Practice (SOP) (Appendix A-5) have been followed; AND</p> <p>Student requires an initial assessment to determine strengths, mental health needs and recommendations, when the Student Support Team (SST), IEP, or MP Team, in consultation with the DOE's psychologists, determines that additional information provided by the EBA Comprehensive is needed.</p>
<b>Authorization</b>	<p>DOE Standards of Practice (SOP) (Appendix A-5c) have been followed, and if procured, Procurement Procedures (PP) have been followed.</p>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p>If procured, prior authorization via a completed DOE procurement work order is required for each evaluation. The procured flat rate reflects the time required for completing the review of data, assessment process, intervention planning, final report, and feedback session, There is no payment for travel time, wait time, appointment no-shows, or cancellations.</p> <p>Event is only billable upon completion of the EBA and report must be submitted to the IEP/MP Care Coordinator before submitting an invoice claim and before payment will be made.</p> <p>Maximum Billable: Flat rate per EBA is required.</p>
<b>Completion of Service</b>	<p>The service is complete when all of the following steps are complete:</p> <p>Step 1. The assessment has been completed; AND</p> <p>Step 2. The written EBA Comprehensive report is submitted to the DOE and meets the service specifications as set forth in the Service Description section, as described above. (See Emotional Behavioral Assessment form.) EBA Comprehensive reports not meeting these specifications will be returned to the assessor for correction. Payment may not be made or a reimbursement will be sought if assessments are not corrected according to prescribed specifications.</p> <p>Step 3. Scores and plotted profiles of the CAFAS, BASC-2, CALOCUS and Achenbach forms should be attached to the EBA Comprehensive report.</p> <p>Step 4. Providers are required to input assessment and data information in the ISPED (or other designated database) modules such as IEP/MP, and other modules that DOE requires, within the timeframe required by the DOE.</p> <p>Step 5. Feedback session of the assessment results has been completed.</p>

### Staffing Requirements:

Assessors must meet one of the following requirements:

1. School Psychologist or Clinical Psychologist employed by the DOE specifically credentialed to conduct mental health/emotional health assessment services as allowed under exemption in applicable state laws and regulations.
- OR**
2. Hawaii licensed psychologist or psychiatrist **AND** has a minimum of one (1) year of supervised training in child and adolescent assessment.
- OR**
3. Individual who possesses a Master's degree, doctoral degree, or is a doctoral candidate in a graduate program in psychology or psychiatry from a regionally or nationally accredited program **AND** has a minimum of one (1) year of documented training and supervised experience in child and adolescent assessment, **AND** works under the supervision of a licensed psychologist or

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

psychiatrist meeting standards above. [NOTE: At a minimum, the supervisor must review all prior reports/data; review all current assessment data; and participate in the interpretation of data, and the development of a diagnoses and recommendations. The supervisor is to sign the report acknowledging responsibility for the assessment.]

OR

4. A licensed mental health professional who is qualified to conduct Emotional Behavioral Assessments (Mental Health Assessments) for Medicaid reimbursement.

### **Service Operations:**

1. Parent(s), student, and staff associated with the assessment were actively involved in the process.
2. Report contains all required service content components, utilizing the DOE prescribed report format. See Emotional Behavioral Assessment format in the Appendix A-15.
3. Report is typed.
4. Report is submitted within one week of assessment completion.
5. The EBA Comprehensive report addresses a student's needs and does not specify a particular service, program, provider or eligibility status.
6. Report includes original signature(s) of the assessor (and supervisor as necessary) acknowledging responsibility for the assessment.

### **Documentation:**

Assessors are required to input assessment and data information in the ISPED (or other designated database) modules and other modules that DOE requires, within the timeframe required by the DOE.

Written report contains all required service content components, utilizing the DOE prescribed report format. Refer to the Emotional Behavioral Assessment format in the Appendix A-15.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### C. EMOTIONAL BEHAVIORAL ASSESSMENTS- ANNUAL UPDATE

<b>Service Description</b>	Emotional Behavioral Annual Assessment involves a strengths-based approach to <b>update</b> identification of the student's needs in the context of school, family and community. This service includes completion of annual assessments to <i>determine current mental health needs and recommendations if required by the IEP/MP Team, for continued DOH services, or specific reasons/purposes posed by referral source.</i>
<b>Services Offered</b>	<p>An Emotional Behavioral Assessment Annual Update includes <u>all</u> of the following: Make appointment with the youth and family within one (1) week of procurement;</p> <ol style="list-style-type: none"> <li>1. Contact the family and arrange for appointment with the student and family within one week of referral.</li> <li>2. Conduct the assessment within two weeks of referral. Parental consent for assessment and release of information is covered by the IEP/MP consent. No additional parental consent for assessment or release is needed by the assessor or contracted provider.</li> <li>3. Report any additions and changes in the developmental, psychosocial, medical, educational, and legal histories since the last assessment as provided by the school student services coordinator (SSC).</li> <li>4. Interview school personnel -- teachers, counselors, behavior specialists and/or administrators, or other persons that have first-hand knowledge of the functioning of the student.</li> <li>5. Interview family/significant others.</li> <li>6. Interview student face-to-face.</li> <li>7. Administer assessment instruments, if not provided, to include a minimum the BASC-2, CALOCUS, CAFAS and Achenbach checklists from home (CBCL) and school (TRF) and student (YSR), if 11 years or older.</li> <li>8. Submit a complete written report, utilizing the Emotional Behavioral Assessment Annual Update format in the Appendix A-16, within 30 days of referral to the IEP/MP Care Coordinator. A written report shall include all of the following: <ol style="list-style-type: none"> <li>a. Behavioral observations and Mental Status Exam must include <u>all</u> of the following: <ol style="list-style-type: none"> <li>i. Appearance, attitude, and behavior;</li> <li>ii. Orientation;</li> <li>iii. Affect and mood;</li> <li>iv. Thought content/processes: <ol style="list-style-type: none"> <li>1. Fund of knowledge;</li> <li>2. Intelligence;</li> <li>3. Cognitive processes;</li> <li>4. Memory;</li> <li>5. Insight;</li> <li>6. Judgment; and</li> <li>7. Homicidal/suicidal risk.</li> </ol> </li> </ol> </li> <li>b. Assessment Results and interpretation.</li> </ol> </li> </ol>



## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<ul style="list-style-type: none"> <li>c. Student and Family Strengths.</li> <li>d. Clinical Formulation/Justification of Diagnoses (include severity and duration of diagnoses; for Rule/Out or Provisional diagnoses, explain what needs to occur to obtain a more definite diagnosis).</li> <li>e. Diagnostic Impression: DSM IV-5 Axes.</li> <li>f. The written report shall address a student's needs and shall not specify a particular service, program, provider, or eligibility status. The IEP/MP Team determines whether a student needs a fully self-contained class, residential placement, at-home instruction, etc. All recommendations shall be supported by empirical research.</li> <li>g. Source of Additional Information: most recent emotional/behavioral reports (attach reports).               <ul style="list-style-type: none"> <li>i. Admission and Discharge summaries</li> <li>ii. Intervention summaries including provider progress reports</li> <li>iii. Consultations</li> </ul> </li> <li>h. Provider information including signature, name and degree(s) of the evaluator, and the position and name of institution/organization of the evaluator is affiliated (if indicated and appropriate).</li> </ul>
<b>Referral Criteria</b>	<p>DOE Standards of Practice (SOP) (Appendix A-5) have been followed; and</p> <p>Student requires an annual assessment to determine current mental health needs and recommendations, if required by the IEP/MP Team, for continued DOH services or for specific reasons/purposes posed by referral source.</p>
<b>Authorization</b>	<p>DOE Standards of Practice (SOP) (Appendix A-5) have been followed, and if procured, Procurement Procedures (PP) have been followed.</p> <p>If procured, prior authorization via a completed DOE procurement work order is required for each evaluation. The procured flat rate reflect the time required for completing the data gathering, assessment process, feedback session and final report. There is no payment for travel time, wait time, appointment no-shows, or cancellations.</p> <p>Event is only billable upon completion of the evaluation and the report must be submitted to the appropriate IEP/MP Coordinator before submitting an invoice claim and before payment will be made.</p> <p>Maximum Billable: Flat rate is required.</p>
<b>Completion of Service</b>	<p>The service is complete when all of the following steps are complete:</p> <p>Step 1. The assessment has been completed; AND</p>

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

	<p>Step 2. The written EBA Annual Update report is submitted to the DOE and meets service specifications as set forth in the Service Description section, as described above. (See Appendix A-16, Emotional Behavioral Assessment Annual Update.) EBA Annual Update reports not meeting these specifications will be returned to the assessor for correction. Payment may not be made or a reimbursement will be sought if assessments are not corrected according to prescribed specifications.</p> <p>Step 3. Scores and plotted profiles of the CAFAS, BASC-2, CALOCUS and Achenbach forms should be attached to the EBA Annual Update report.</p> <p>Step 4. Assessors are required to input assessment and data information in the ISPED (or other designated database) modules such as IEP/MP, and other modules that DOE requires, within the timeframe required by the DOE.</p> <p>Step 5. Feedback session of the assessment results has been completed.</p>
--	---

### Staffing Requirements:

Assessors must meet one of the following requirements:

1. School Psychologist or Clinical Psychologist employed by the DOE specifically credentialed to conduct mental health/emotional health assessment services as allowed under exemption in applicable state laws and regulations.
- OR**

- 2. Hawaii licensed psychologist or psychiatrist **AND** has a minimum of one (1) year of supervised training in child and adolescent assessment.
- OR**

- 3. Individual who possesses a Master's degree, doctoral degree, or is a doctoral candidate in a graduate program in psychology or psychiatry from a regionally or nationally accredited program **AND** has a minimum of one (1) year of documented training and supervised experience in child and adolescent assessment, **AND** works under the supervision of a licensed psychologist or psychiatrist meeting standards above. **[NOTE: At a minimum, the supervisor must review all prior reports/data; review all current assessment data; and participate in the interpretation of data, and the development of a diagnoses and recommendations. The supervisor is to sign the report acknowledging responsibility for the assessment.]**
- OR**

- 4. Licensed mental health professional who is qualified to conduct Emotional Behavioral Assessments (Mental Health Assessments) for Medicaid reimbursement.

### Service Operations:

1. Parent(s), student, and staff associated with the assessment were actively involved in the process.
2. The EBA Annual Update report contains all required service content components, utilizing the DOE's prescribed report format. Refer to the Appendix A-16, Emotional Behavioral Assessment Annual Update Form.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

3. Report is typed.
4. Report is submitted within 30 days of referral.
5. The EBA Annual Update report addresses a student's strengths and needs and does not specify a particular service, program, provider or eligibility status.
6. Report includes original signature(s) of the assessor (and supervisor as necessary,) acknowledging responsibility for the assessment.

### **Documentation:**

Assessors are required to input assessment information and data in the ISPED (or other designated database) modules and other modules that DOE requires, within the timeframe required by the DOE.

Written report contains all required service content components, utilizing the DOE prescribed report format. See Appendix A-16, Emotional Behavioral Assessment Annual Update.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### D. INDIVIDUAL COUNSELING

<b>Service Description</b>	<p>Individual counseling services include regularly scheduled, face-to-face sessions with a student and are designed to improve student functioning to allow increased benefits from his/her educational program. These services may be provided in the school, community or home setting or, if appropriate, in the provider's office, in a setting best suited to address IEP/MP goals and objectives.</p> <p>Individual counseling includes evidence based best practice interventions involving written service plans linked to behavioral support plans and IEP/MP goals and objectives. It also includes cognitive-behavioral strategies, systemic interventions, crisis planning and facilitating access to other community services and supports as needed to improve overall functioning and increase independence.</p> <p>Individual counseling sessions may include a brief conference with the parent, if appropriate (which shall be included as part of the service). Specific objectives for individual counseling sessions may include: reduction of symptoms; increasing behavioral control; improving attention, communication, social, coping, anger management, problem-solving, and other skills. Interventions are strengths- and evidence-based and tailored to address identified student needs and shall be evaluated for effectiveness at least quarterly.</p> <p>Services are designed to promote healthy functioning and to build upon the natural strengths of the school, student/family, and community resources.</p> <p>The provider must have a Student Service Plan for each student seen in individual counseling. (See Appendix A-22) The service plan must be in written form, and responds to those IEP/MP Goals and Objectives which pertain to school-based behavioral health needs. The Student Service Plan shall augment the student's current Behavioral Support Plan (BSP) which addresses the student's strengths, emotional-behavioral health needs, by describing the provider's immediate objective(s), specific interventions, and target dates for reaching those objectives. The service plan shall also include the provider's focused intervention plans, as well as aspects of crisis and transition/exit plans that are relevant to the role of the provider of individual counseling.</p> <p>The intent of the Student Service Plan is not to supplant or redo the IEP/MP or the current BSP, but rather to ensure that it supports the achievement of the IEP/MP/BSP goals and objectives.</p>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

<b>Services Offered</b>	<p>Individual Counseling includes <u>all</u> of the following:</p> <ol style="list-style-type: none"> <li>1. Access and review all assessment and other historical data available in the student's educational record.</li> <li>2. Participate in the Functional Behavior Assessment/Behavior Support Plan process when requested by the school.</li> <li>3. Assist team with determining eligibility and developing IEP/MP goals and objectives.</li> <li>4. Participate as an IEP/MP team member when requested. If the DOE requires the contracted provider to attend an IEP meeting for the student, authorization must come from a DOE administrator affiliated with the IEP team and be billed under Educational Team Planning Participation.</li> <li>5. Develop a Student Service Plan for each student as described above.</li> <li>6. Implement Student Service Plans for individual students. On an ongoing basis, monitor the effect of interventions in meeting objectives and goals.</li> <li>7. Schedule regular sessions to work with student in accordance with the student's IEP/MP.</li> <li>8. Review the Student Service Plan and adjust interventions, refine understanding of student strengths, needs, goals, and monitor student progress at least every 30 days.</li> <li>9. Develop a written crisis plan in collaboration with the student, family, teachers, and other relevant parties.</li> <li>10. Update crisis intervention and transition/exit plans within the service plan based on such reviews.</li> <li>11. Assist with transition/exit planning in collaboration with IEP/MP team as may be required. Review the written transition/exit plan periodically including exit goals, specific target dates for reaching each goal and other included plan details to determine when counseling can appropriately conclude.</li> <li>12. Foster the integration of services across domains (home, school, and community) as needed.</li> </ol>
<b>Referral Criteria</b>	<p>DOE Standards of Practice (SOP) have been followed and an IEP/MP Team determines the identified student meets at least one of the eligibility criteria as defined in Chapter 53 or 56, and <b>ALL</b> of the following:</p> <ol style="list-style-type: none"> <li>1. The student is experiencing moderate to severe behavioral and/or emotional problems due to a behavioral disorder, manifested by a moderate to severe risk for self-injury, injury to others, delay in appropriate developmental progress, deterioration in ability to fulfill developmentally appropriate responsibilities, presence of stress-related symptoms, decompensation, or relapse;</li> <li>2. The identified behavioral and/or emotional problems interfere with student's ability to gainfully benefit from his/her educational program;</li> </ol>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<ol style="list-style-type: none"> <li>3. There is reasonable expectation that the student will benefit from this service, i.e., that individual counseling will remediate symptoms and/or improve functioning resulting in improved ability to benefit from his/her educational program; AND</li> <li>4. Less restrictive services are not adequate to meet the student's needs based on the documented response to prior intervention.</li> </ol>
<b>Authorizations</b>	<p>DOE Standards of Practice (SOP) have been followed, and if procured, Procurement Procedures (PP) have been followed.</p> <p>If procured, prior authorization via a completed DOE procurement work order is required for the service.</p> <p>Individual counseling services can be of varying degrees of intensity and complexity depending upon the student/family/school situation and needs. Regular sessions are scheduled per the service plan in response to the IEP/MP/BSP and typically will decrease in frequency as needs are met and goals are reached. These services are intended to be focused and time-limited with services reduced and discontinued as student/family are able to function more effectively. The usual course of intervention is six (6) to twenty-four (24) individual sessions, or six months, or as specified per the IEP/MP.</p> <ol style="list-style-type: none"> <li>1. The IEP/MP team recommends these services. The scope and nature of services are collaboratively determined by the IEP/MP team.</li> <li>2. A normal session may consist of up to twelve units, or one hour per month of face-to-face individual counseling as appropriate for the student's age and demonstrated ability to benefit.</li> </ol> <p>For contracted services, telephone contacts, documentation or reporting requirements, and logistical planning/preparation shall be an included cost of the service. There is no payment for phone calls, travel time, wait time, no-shows, or cancellations.</p> <p>Absence of the ISPED (or other designated database) Quarterly Progress Report which incorporates the contents of the SBBH Quarterly Progress Report will be constructive proof that the services did not occur and the amount billed will be subject to refund.</p> <p>Maximum Billable: 48 units per month or Per IEP/MP (1 Unit = 5 Minutes; 12 Units = 1 Hour)</p>
<b>Continuing Service Criteria</b>	<p><i>Continuation of services will be based on the student's progress toward IEP/MP goals and objectives.</i></p>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p>All of the following criteria must be met as determined by IEP/MP Team review of service documentation, plans and progress as specified in the Student Service Plan, BSP and IEP/MP:</p> <ol style="list-style-type: none"><li>1. All referral criteria continue to be met;</li><li>2. Services are being provided per the IEP/MP as documented in progress reports and plan reviews;</li><li>3. There are regular and timely assessments, and documentation of student/family response to interventions. Timely and appropriate modifications to the service plan have been made that are consistent with the student/family's status;</li><li>4. A transition/exit plan has been formulated, regularly reviewed, revised if appropriate, and appropriately implemented in a timely manner, identifies specific transition/exit goals to be met, and includes specific target dates for reaching each goal;</li><li>5. At least <u>one</u> of the following criteria must be met:<ol style="list-style-type: none"><li>a. Symptoms or behaviors persist at a level of severity that was documented upon referral, the projected time frame for attainment of IEP/MP/BSP goals as documented in the progress notes has not been reached, and a less restrictive level of care would not adequately meet student's needs. Note: In this situation the IEP/MP Team may need to reconvene, and the BSP and service plans may need to be adjusted to better meet the student's needs. If ongoing interventions and adjustments are not effective, alternative services and levels of care may need to be explored;</li></ol><p style="text-align: center;"><b>OR</b></p><li>b. Student is demonstrating progress, behavioral goals/objectives have not yet been met, but there is reason to believe that goals can be met with continued individual counseling services, and a less intensive level of care would not adequately meet student needs;</li></li></ol> <p style="text-align: center;"><b>OR</b></p> <li>c. Minimal progress toward behavioral goals has been demonstrated, the BSP and service plans have been modified to more effectively address needs, and there is reason to believe that goals can be met by continuing individual counseling services, and a less intensive level of care would not adequately meet student needs;</li> <p style="text-align: center;"><b>OR</b></p> <li>d. New symptoms or maladaptive behaviors have emerged, plans have been modified to address these additional needs, the needs can be safely and effectively addressed through individual counseling services, and a less intensive level of care would not adequately meet student needs.</li>
--	---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

<b>Verification of Service Session</b>	<p>1. Service session is complete when visit records reflecting all contacts have been entered into ISPED (or other designated database) (or other specified) within twenty-four (24) hours. Such information includes IEP/MP information, visit records, progress reports and other professional information or data that DOE may require;</p> <p style="text-align: center;"><b>AND</b></p> <p>2. If procured, the provider has completed the Service Verification Form (See Appendix A-21)</p>
<b>Completion of Service</b>	<p>DOE determines the services of the contracted provider are no longer necessary;</p> <p style="text-align: center;"><b>OR</b></p> <p>Student is no longer in need of or eligible for services, as determined by the IEP/MP team, due to at least <u>one</u> of the following:</p> <p>1. Targeted symptoms and/or maladaptive behaviors have abated to a level of severity which no longer requires this level of care as documented by attainment of goals in the BSP;</p> <p style="text-align: center;"><b>OR</b></p> <p>2. Student has demonstrated minimal or no progress toward BSP goals for a <b>three month period</b> and appropriate modifications of plans have been made and implemented with no significant success, suggesting the student is not benefiting from individual counseling services at this time;</p> <p style="text-align: center;"><b>OR</b></p> <p>3. Student exhibits new symptoms and/or maladaptive behaviors which cannot be safely and effectively addressed through individual counseling services;</p> <p style="text-align: center;"><b>OR</b></p> <p>4. Student no longer meets referral criteria for this service;</p> <p style="text-align: center;"><b>OR</b></p> <p>5. Student does not meet eligibility criteria.</p>

### Staffing Requirements:

Individual counseling services shall be provided by personnel that meet one of the following requirements:

1. Counseling services may be provided by qualified DOE personnel who are in positions whose class specifications or job descriptions describe counseling services as part of the assigned duties and responsibilities (i.e. Behavioral Specialists, School Counselors, School Social Workers, School or Clinical Psychologists).

**OR**

2. Hawaii licensed social worker, marriage/family therapist, psychiatric nurse specialist, psychologist, or psychiatrist, National Certified Counselor, Option C only, **AND** has a minimum of one year of supervised training and experience in the provision of child and adolescent mental health services,

**OR**



---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

3. Individual who possesses an advanced (graduate level) professional degree in social work, marriage/family counseling, psychiatric nursing, psychology, psychiatry, counseling or behavioral science from a nationally or regionally accredited program AND has a minimum of two years of supervised training and experience in the provision of child and adolescent mental health services.

**OR**

4. Individual who possesses a masters or higher degree from a national or regionally accredited university; is eligible to be certified/licensed as a School Psychologist by one of the 50 states; and has at least two years of experience as a School Psychologist which involved working directly with children.

**OR**

5. Individual who possesses an advanced (graduate level) professional degree in social work, marriage/family counseling, psychiatric nursing, psychology, psychiatry, counseling or behavioral science, from a nationally or regionally accredited program **AND** has a minimum of one year of supervised training and experience in the provision of child and adolescent mental health services, **AND** is currently working under the supervision of personnel meeting criteria 2 or 3 above.

**OR**

6. Licensed Mental Health Counselor in the State of Hawaii as of 2005 having at least 1 year of experience in behavioral or mental health.

### **Service Operations:**

1. The counseling provider must contact the school or student's teacher/student/family within one week of referral and be able to initiate service within two (2) weeks of referral unless otherwise determined by the IEP/MP Care Coordinator.
2. Written Student Service Plan is completed within one (1) week of referral, regularly reviewed, and updated.
3. Crisis plan is completed within one (1) week of referral, regularly reviewed, and updated.
4. Transition/Exit plans is completed, regularly reviewed, and submitted.
5. Input required information into ISPED (or other designated database) and the SBBH supplemental database as required, within the timeframe specified by the DOE.
6. SBBH Quarterly Progress Reports are completed according service specifications. (See Appendix A-19.)
7. Evidence of credentialing is available.

### **Documentation:**

Specific required documentation includes all of the following:

1. Develop and review a (written) Student Service Plan with the student, family, and school prior to initiating such services as may be specified in the IEP/MP. Further review the service plan with the student, family and school as required. The service plan should reference IEP/MP goals and objectives, include all SBBH related aspects of the student's Behavioral Support plan and add planning information and details to be utilized by the counseling provider in effectively providing SBBH service(s) to address the student's goals and objectives. The Student Service Plan shall be turned in to the IEP/MP Care Coordinator within one (1) week of referral.
2. Contracted providers are required to utilize the specified Student Service Plan. See Appendix A-22. DOE employees shall ensure that the student has a service plan that includes all components of the Student Service Plan and may utilize the same or similar form.
3. Develop a written crisis plan in collaboration with other involved professionals, and review the plan with the student, family and school within one (1) week of referral. The plan is to be signed by all parties involved in the review. Update this plan as needed to effectively meet changing student needs in relation to family/school needs.

## **INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES**

---

4. Prepare written transition and exit plans. Review with the student/family/school within four weeks of referral and update these plans as needed.
5. Completion of visit records reflecting all contacts and entered into ISPED (or other designated database) within twenty-four (24) hours. Providers shall input information in the ISPED (or other designated database) (or other specified) modules as may be required for each service description. Such information includes IEP/MP information, visit records, progress reports and other professional information or data that DOE may require.
6. By the 5<sup>th</sup> of every calendar month, input required data into ISPED (or other designated database) and the SBBH supplemental database, reporting on the student's end-of-month status, as well as service activities and student progress over the entire month. If the 5<sup>th</sup> falls on the weekend or a holiday, data input is due on the preceding school day.
7. SBBH Quarterly Progress Reports must address student progress in meeting IEP/MP goals, and shall be completed and made available to the student's IEP/MP Care Coordinator 2 weeks before the end of the quarter. Also, a report is due at the end of each ESY period, if student is eligible for ESY. See Appendix A-19.
8. Tracking of outcome measures shall, at a minimum, include quarterly completion of the BASC-2 Student Observation System (SOS) in the setting of greatest difficulty, as well as, this data. Data shall be incorporated into the SBBH Quarterly Progress Report. The provider shall incorporate the contents of the SBBH Quarterly Progress Report into the ISPED (or other designated database) quarterly progress report.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### E. GROUP COUNSELING

<b>Service Description</b>	<p>Group counseling services include regularly scheduled membership in service provider facilitated groups of three (3) to twelve (12) students, and is designed to improve student functioning in their identified areas of concern.</p> <p>Group counseling services are focused, evidenced based and typically time-limited. Group counseling is contra-indicated for conduct disordered students. Students shall be exited from the group when appropriate IEP/MP and BSP goals and objectives are reached. Group counselors may utilize verbal instruction, modeling, coaching, role-playing, behavioral practice and other group-oriented experiential techniques.</p> <p>Specific goals may include: skill development, reduction of reoccurring problem behaviors; reduction of symptoms; increase in behavioral control; and improved attention, communication, social, recreational, coping, anger management, problem-solving, and other daily educational or living skills. Interventions utilized are to be strengths- and evidence-based and tailored to address identified needs of the individual student.</p> <p>Services are designed to promote healthy independent functioning and to build upon the natural strengths of the student and community resources.</p> <p>The counseling provider must have a Student Service Plan for each student seen in group counseling. The service plan must be in written form, and responds to those IEP/MP Goals and Objectives which pertain to school-based behavioral health needs. A Student Service Plan shall augment the student's current Behavioral Support Plan (BSP) which addresses the student's emotional-behavioral health needs, by describing the counseling provider's immediate objective(s), specific interventions, and target dates for reaching those objectives. The service plan shall also include the provider's focused intervention plans, as well as aspects of crisis and transition/exit plans that are relevant to the role of the provider of group counseling. See Student Service Plan in Appendix A-22.</p> <p>The intent of the service plan is not to supplant or redo the IEP/MP or the current BSP, but rather to ensure that it supports the achievement of the IEP/MP/BSP goals and objectives.</p>
<b>Services Offered</b>	<p>Group counseling includes <u>all</u> of the following:</p> <ol style="list-style-type: none"><li>1. Access and review all assessment and other historical data available in the student's educational record.</li><li>2. Participate in the Functional Behavior Assessment/Behavior Support Plan process as when requested by the school.</li><li>3. Assist team with determining eligibility and developing IEP/MP goals and objectives.</li><li>4. Participate as an IEP/MP team member when requested by the school. If the DOE requires the contracted provider to</li></ol>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p>attend an IEP meeting for the student, authorization must come from a DOE administrator affiliated with the IEP team and be billed under Educational Team Planning Participation.</p> <ol style="list-style-type: none"> <li>5. Develop a Student Service Plan for each student as described above.</li> <li>6. Implement service plans for individual students. On an ongoing basis, monitor the effect of interventions in meeting objectives and goals.</li> <li>7. Schedule regular sessions to work with student in accordance with the student's IEP/MP.</li> <li>8. Review the service plan and adjust interventions, refine understanding of student strengths, needs, goals, and monitor student progress at least every 30 days.</li> <li>9. Develop a written crisis plan in collaboration with the student, family, teachers, and other relevant parties.</li> <li>10. Update crisis intervention and transition/exit plans within the service plan based on such reviews.</li> <li>11. Assist with transition/exit planning in collaboration with IEP/MP team as may be required. Review the written transition/exit plan periodically including exit goals, specific target dates for reaching each goal and other included plan details to determine when counseling can appropriately conclude.</li> <li>12. Foster the integration of services across domains (home, school, and community) as needed.</li> </ol>
<b>Referral Criteria</b>	<p>DOE Standards of Practice (SOP) have been followed and an IEP or MP Team determines the identified student meets at least one of the eligibility criteria as defined in Chapter 53 or 56, and <b>ALL</b> of the following:</p> <ol style="list-style-type: none"> <li>1. The student is experiencing moderate to severe behavioral and/or emotional problems due to a behavioral disorder, manifested by a moderate to severe risk for self-injury, injury to others, delay in appropriate developmental progress, deterioration in ability to fulfill developmentally appropriate responsibilities, presence of stress-related symptoms, decompensation, or relapse;</li> <li>2. The identified behavioral and/or emotional problems interfere with student's ability to gainfully benefit from his/her educational program;</li> <li>3. There is reasonable expectation that the student will benefit from this service, i.e., that group counseling will remediate symptoms and/or improve functioning resulting in improved ability to benefit from his/her educational program; AND</li> <li>4. Less restrictive services are not adequate to meet the student's needs based on the documented response to prior intervention.</li> </ol>
<b>Authorizations</b>	<p>DOE Standards of Practice (SOP) have been followed, and if procured, Procurement Procedures (PP) have been followed.</p>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p>If procured, prior authorization via a completed DOE procurement work order is required for the service.</p> <ol style="list-style-type: none"> <li>1. Group counseling services can be of varying degrees of intensity and complexity depending upon the student's situation and needs. Regular sessions are scheduled per the service plan in response to the IEP/MP and BSP and typically will be time-limited and will decrease in frequency as needs are met and goals are reached.</li> <li>2. The IEP/MP Team recommends these services. The scope and nature of services are collaboratively determined by the IEP/MP.</li> <li>3. A normal session should consist of twelve units, or a one hour session per month of group counseling.</li> <li>4. If procured, the unit cost shall reflect a 5-minute unit rate. The rate shall reflect the cost for providing the service to the individual student, not the group.</li> </ol> <p>Note: For contracted services, telephone contacts, documentation and reporting requirements, and logistical planning/preparation shall be an included cost of the service. There is no payment for phone calls, travel time, wait time, no-shows, or cancellations.</p> <p>Absence of the ISPED (or other designated database) Quarterly Progress Report which incorporates the contents of the SBBH Quarterly Progress Report will be constructive proof that the services did not occur and the amount billed will be subject to refund.</p> <p>Maximum Billable: 48 units per month or per IEP/MP (1 Unit = 5 Minutes; 12 Units = 1 Hour)</p>
<b>Reauthorization Criteria</b>	<p>Continuation of services will be based on the student's progress toward IEP/MP goals and objectives.</p> <p><u>All</u> of the following criteria must be met as determined by IEP/MP Team review of service documentation, plans and progress as specified in the Student Service Plan, BSP and IEP/MP:</p> <ol style="list-style-type: none"> <li>1. All referral criteria continue to be met;</li> <li>2. Services are being provided per the IEP/MP as documented in progress reports and plan reviews;</li> <li>3. There are regular and timely assessments, and documentation of student/family response to interventions. Timely and appropriate modifications to the service plan have been made that are consistent with the student/family's status;</li> <li>4. A transition/exit plan has been formulated, regularly reviewed, revised if appropriate, and appropriately implemented in a timely manner, identifies specific transition/exit goals to be met, and includes specific target dates for reaching each goal; AND</li> </ol>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p>5. At least <u>one</u> of the following criteria must be met:</p> <ul style="list-style-type: none"> <li>a. Symptoms or behaviors persist at a level of severity that was documented upon referral, the projected time frame for attainment of IEP/MP/BSP goals as documented in the progress notes has not been reached, and a less restrictive level of care would not adequately meet student's needs. Note: In this situation the IEP/MP Team may need to reconvene, and the BSP and service plans may need to be adjusted to better meet the student's needs. If ongoing interventions and adjustments are not effective, alternative services and levels of care may need to be explored;</li> <li>b. Student is demonstrating progress, behavioral goals/objectives have not yet been met, but there is reason to believe that goals can be met with continued group counseling services, and a less intensive level of care would not adequately meet student needs;</li> <li>c. Minimal progress toward behavioral goals has been demonstrated, the BSP and service plans have been modified to more effectively address needs, and there is reason to believe that goals can be met by continuing group counseling services, and a less intensive level of care would not adequately meet student needs; OR</li> <li>d. New symptoms or maladaptive behaviors have emerged, plans have been modified to address these additional needs, the needs can be safely and effectively addressed through group counseling services, and a less intensive level of care would not adequately meet student needs.</li> </ul>
<b>Verification of Service Session</b>	<p>1. Service session is complete when visit records reflecting all contacts have been entered into ISPED (or other designated database) (or other specified) within twenty-four (24) hours. Such information includes IEP/MP information, visit records, progress reports and other professional information or data that DOE may require;</p> <p style="text-align: center;"><b>AND</b></p> <p>2. If procured, the provider has completed the Service Verification Form (See Appendix A-21)</p>
<b>Completion of Service</b>	<p>DOE determines the services of the contracted provider are no longer necessary;</p> <p style="text-align: center;"><b>OR</b></p> <p>The IEP/MP Team determines that student is no longer in need of or eligible for services due to at least <u>one</u> of the following:</p> <ul style="list-style-type: none"> <li>1. Targeted symptoms and/or maladaptive behaviors have abated to a level of severity which no longer requires this level of care as documented by attainment of goals in the IEP/MP;</li> </ul>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

	<p style="text-align: center;"><b>OR</b></p> <p>2. Student has demonstrated minimal or no progress toward IEP/MP goals for a <b>three month period</b> and appropriate modifications of BSP and service plans have been made and implemented with no significant success, suggesting the student is not benefiting from group counseling services at this time;</p> <p style="text-align: center;"><b>OR</b></p> <p>3. Student exhibits new symptoms and/or maladaptive behaviors which cannot be safely and effectively addressed through group counseling services;</p> <p style="text-align: center;"><b>OR</b></p> <p>4. Student no longer meets referral criteria for this service;</p> <p style="text-align: center;"><b>OR</b></p> <p>5. Student no longer meets eligibility criteria.</p>
--	---

### Staffing Requirements:

Group counseling services shall be provided by personnel that meet one of the following requirements:

1. Counseling services may be provided by qualified DOE personnel who are in positions whose class specifications or job descriptions describe counseling services as part of the assigned duties and responsibilities (i.e. Behavioral Specialists, School Counselors, School Social Workers, School or Clinical Psychologists).
- OR**
2. Hawaii licensed social worker, marriage/family therapist, psychiatric nurse specialist, psychologist, or psychiatrist, National Certified Counselor, option C only, **AND** has a minimum of one year of supervised training and experience in the provision of child and adolescent mental health services,
- OR**
3. Individual who possesses an advanced (graduate level) professional degree in social work, marriage/family counseling, psychiatric nursing, psychology, psychiatry, counseling or behavioral science from a nationally or regionally accredited program **AND** has a minimum of two years of supervised training and experience in the provision of child and adolescent mental health services,
- OR**
4. Individual who possesses a masters or higher degree from a national or regionally accredited university; is eligible to be certified/licensed as a school psychologist by one of the 50 states; and has at least two years of experience as a school psychologist which involved working directly with children.
- OR**
5. Individual who possesses an advanced (graduate level) professional degree in social work, marriage/family counseling, psychiatric nursing, psychology, psychiatry, counseling or behavioral science, from a nationally or regionally accredited program **AND** has a minimum of one year of supervised training and experience in the provision of child and adolescent mental health services, **AND** is currently working under the supervision of personnel meeting criteria 2 or 3 above.
- OR**
6. Licensed Mental Health Counselor in the State of Hawaii as of 2005 having at least 1 year of experience in behavioral or mental health.

### Service Operations:

1. The counseling provider must contact the school/student/family within one week of procurement and be able to initiate service within two (2) weeks of referral unless otherwise determined by the IEP/MP Care Coordinator.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

2. Written Student Service Plan is completed within one (1) week of referral, regularly reviewed, and updated.
3. Crisis plan is completed within one (1) week of referral, regularly reviewed, and updated.
4. Transition/Exit plans is completed, regularly reviewed, and submitted.
5. Input required information into ISPED (or other designated database) and the SBBH supplemental database as required, and within the timeframe specified by the DOE.
6. SBBH Quarterly Progress Reports are completed according to service specifications. See Appendix A-19.
7. Evidence of credentialing must be available.

### **Documentation:**

Specific required documentation includes all of the following:

1. Develop and review a (written) Student Service Plan with the school or student's teacher, student, and family prior to initiating such services as may be specified in the IEP/MP. Further review the service plan with the student, family and school as required. The service plan should reference IEP/MP goals and objectives, include all SBBH related aspects of the student's Behavioral Support plan and add planning information and details to be utilized by the provider in effectively providing SBBH service(s) to address the student's goals and objectives. The Student Service Plan shall be turned in to the IEP/MP Care Coordinator within one (1) week of referral.
2. Contracted providers are required to utilize the specified Student Service Plan. See Appendix A-22. The DOE employee providing counseling shall ensure that the student has a service plan which includes all components of the Student Service Plan and may utilize the same or similar form.
3. Develop a written crisis plan in collaboration with other involved professionals, and review the plan with the student, family and school within one (1) week of referral. The plan is to be signed by all parties involved in the review. Update this plan as needed to effectively meet changing student needs in relation to family/school needs.
4. Prepare written transition and exit plans. Review with the student/family/school within four weeks of referral and update these plans as needed.
5. Completion of visit records reflecting all contacts and entered into ISPED (or other designated database) within twenty-four (24) hours. Counseling providers shall input information in the ISPED (or other designated database) modules as may be required for each service description. Such information includes IEP/MP information, visit records, progress reports and other professional information or data that DOE may require.
6. By the 5<sup>th</sup> of every calendar month, input required data into ISPED (or other designated database) and the SBBH supplemental database, reporting on the student's end-of-month status, as well as service activities and student progress over the entire month. If the 5<sup>th</sup> falls on the weekend or a holiday, data input is due on the preceding school day.
7. SBBH Quarterly Progress Reports must address student progress in meeting IEP/MP goals, and shall be completed and made available to the student's IEP/MP Care Coordinator within 2 weeks before the end of the quarter. Also a report is due at the end of the ESY period if the student is eligible. See Appendix A-19.
8. Tracking of outcome measures shall, at a minimum, include quarterly completion of the BASC-2 Student Observation System (SOS) in the setting of greatest difficulty, as well as, this data. Data shall be incorporated into the SBBH Quarterly Progress Report. The provider shall incorporate the contents of the SBBH Quarterly Progress Report into the ISPED (or other designated database) quarterly progress report.



---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

### F. PARENT COUNSELING/TRAINING

<b>Service Description</b>	<p>The purpose of Parent Counseling/Training is to educate parents or legal guardians (with whom the student resides) and to provide them with an understanding of the special needs of their student and help them acquire and practice the skills that will allow them to support the implementation of their student's IEP/MP.</p> <p>Topics of instruction may include, but are not limited to information relating to their student's disability and related diagnosis; techniques useful for addressing behavioral issues and information about evidence based strategies.</p> <p>Parent Counseling/Training services include regularly scheduled face-to-face sessions with a student and family designed to facilitate improvement of student/family functioning in ways that allow the student to gain benefit from his/her educational program. These services may be provided in the school, community or home setting; or, if it is appropriate and agreeable to the family, in the counseling/training provider's office.</p> <p>The counseling/training provider must have a Student Service Plan for each student seen in parent counseling/training. The service plan must be in written form, and responds to those IEP/MP Goals and Objectives which pertain to school-based behavioral health needs. The Student Service Plan shall augment the student's current Behavioral Support Plan (BSP) which addresses the student's emotional-behavioral health needs, by describing the provider's immediate objective(s), specific interventions, and target dates for reaching those objectives. The service plan shall also include the provider's focused intervention plans, as well as aspects of crisis and transition/exit plans that are relevant to the role of the provider of parent counseling/training.</p> <p>The intent of the Student Service Plan is not to supplant or redo the IEP/MP or the current BSP, but rather to ensure that it supports the achievement of the IEP/MP/BSP goals and objectives.</p>
<b>Services Offered</b>	<p>Interventions are evidence based and tailored to address identified student needs. Services are designed to promote healthy functioning and to build upon the natural strengths of the student, family and community resources. These services are intended to be time-limited with services first reduced, and then discontinued as student/family are able to function more effectively in achieving educational goals and objectives.</p> <p>Specific interventions may include:</p> <ol style="list-style-type: none"><li>1. Assisting family with developing and maintaining appropriate structure within the home.</li><li>2. Assisting family with the development of effective parenting skills and student management techniques.</li><li>3. Assisting family with developing an increased understanding of their student's symptoms and problematic behaviors, developing effective strategies to address these issues, and</li></ol>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p>encouraging an emphasis on building upon their student's strengths.</p> <p>4. Facilitating involvement and access to community supports and resources as needed.</p>
<b>Referral Criteria</b>	<p>DOE Standards of Practice (SOP) (Appendix A-5e) have been followed and an IEP or MP Team determines that:</p> <ul style="list-style-type: none"> <li>• Parents/legal guardians need education in the understanding of the special needs of their student; and/or</li> <li>• Parents/legal guardians need help in acquiring skills and practicing skills that will allow them to support the implementation of their student's IEP/MP;</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p>The identified student meets at least one of the DOE service eligibility criteria defined in Chapter 53 or 56, and ALL of the following:</p> <ol style="list-style-type: none"> <li>1. The student is exhibiting moderate to severe behavioral and/or emotional problems due to a behavior disorder, manifested by a moderate to severe risk for self-injury, injury to others, delay in appropriate developmental progress, deterioration in ability to fulfill developmentally appropriate responsibilities, presence of stress-related symptoms, decompensation, or relapse;</li> <li>2. The identified behavioral and/or emotional problems significantly interfere with student's ability to gainfully benefit from the his/her educational program;</li> <li>3. Direct family involvement in interventions are essential to the student's progress, i.e., lack of direct family involvement would result in lack of progress or deterioration; AND</li> <li>4. Less restrictive services are not adequate to meet the student needs based on documented response to prior treatment.</li> </ol>
<b>Authorization</b>	<p>DOE Standards of Practice (SOP) (Appendix A-5e) have been followed, and if procured, Procurement Procedures (PP) have been followed.</p> <p>If procured, prior authorization via a completed DOE procurement work order is required for the service.</p> <ol style="list-style-type: none"> <li>1. Parent Counseling/Training services are recommended by the IEP/MP team and procured by the school. The scope and nature of services are collaboratively determined by the IEP/MP team. Parent/Family intervention services may vary in intensity and complexity depending upon the student/family situation and needs.</li> <li>2. Regular sessions are scheduled per service plan to respond to needs identified by the IEP/MP and BSP, and typically will decrease in frequency as needs are met and goals are reached. These services are intended to be time-limited with services reduced and then discontinued as student/family</li> </ol>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p>are able to function more effectively and the student demonstrates progress on educational goals and objectives.</p> <ol style="list-style-type: none"> <li>3. A normal session should consist of twelve units or one hour per month of face-to-face parent counseling/training</li> <li>4. If procured, a billable event is limited to actual Parent Counseling/Training sessions and the Parent Counseling/Training session must consist of face-to-face contact with the persons who are the recipient of the training.</li> </ol> <p>Note: For contracted services, telephone contacts, documentation or reporting requirements, and logistical planning/preparation shall be an included cost of the service. There is no payment for time spent on phone calls, travel time, wait time, no-shows, or cancellations.</p> <p>Absence of the ISPED (or other designated database) quarterly progress report which incorporates the contents of the SBBH Quarterly Progress Report will be constructive proof that the services did not occur and the amount billed will be subject to refund.</p> <p>Maximum Billable: 48 units per month or per the IEP/MP. (1 Unit = 5 Minutes; 12 Units = 1 Hour)</p>
<b>Continuing Service Criteria</b>	<p>Parent Counseling/Training must be of a time-limited basis and consist of evidence based instructional interventions. In addition, the service will follow the service plan and result in the student's progress in educational goals and objectives as evidenced by collected data.</p>
<b>Verification of Service Session</b>	<ol style="list-style-type: none"> <li>1. Service session is complete when visit records reflecting all contacts have been entered into ISPED (or other designated database) (or other specified) within twenty-four (24) hours. Such information includes IEP/MP information, visit records, progress reports and other professional information or data that DOE may require;</li> </ol> <p style="text-align: center;"><b>AND</b></p> <ol style="list-style-type: none"> <li>2. If procured, the provider has completed the Service Verification Form (See Appendix A-21.)</li> </ol>
<b>Completion of Service</b>	<ol style="list-style-type: none"> <li>1. Parent Counseling/Training service plan has been implemented and completed;</li> </ol> <p style="text-align: center;"><b>OR</b></p> <ol style="list-style-type: none"> <li>2. The IEP/MP team determined that the provision of this service is no longer needed;</li> </ol> <p style="text-align: center;"><b>OR</b></p> <ol style="list-style-type: none"> <li>3. The DOE determines the services of the contracted provider are no longer necessary.</li> </ol>

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

### Staffing Requirements:

Parent Counseling/Training services shall be provided by personnel that meet one of the following requirements:

1. Counseling services may be provided by qualified DOE personnel who are in positions whose class specifications or job descriptions describe counseling/training services as part of the assigned duties and responsibilities (i.e. Behavioral Specialists, School Counselors, School Social Workers, School or Clinical Psychologists).  
**OR**
2. Hawaii licensed social worker, marriage/family therapist, psychiatric nurse specialist, psychologist, or psychiatrist, National Certified Counselor, option C only, **AND** has a minimum of one year of supervised training and experience in the provision of child and adolescent mental health services.  
**OR**
3. Individual who possesses an advanced (graduate level) professional degree in social work, marriage/family counseling, psychiatric nursing, psychology, psychiatry, counseling or behavioral science from a nationally or regionally accredited program **AND** has a minimum of two years of supervised training and experience in the provision of child and adolescent mental health services,  
**OR**
4. Individual who possesses a masters or higher degree from a national or regionally accredited university; is eligible to be certified/licensed as a School Psychologist by one of the 50 states; and has at least two years of experience as a school psychologist which involved working directly with children.  
**OR**
5. Individual who possesses an advanced (graduate level) professional degree in social work, marriage/family counseling, psychiatric nursing, psychology, psychiatry, counseling or behavioral science, from a nationally or regionally accredited program **AND** has a minimum of one year of supervised training and experience in the provision of child and adolescent mental health services, **AND** currently works under the supervision of personnel meeting criteria 2 or 3 above.  
**OR**
6. Service delivery must be preceded by a thorough assessment of the youth and their family so that an appropriate and effective treatment plan can be developed.

### Service Operations:

1. The counselor/trainer must contact the student/family within one week of procurement and be able to initiate service within two (2) weeks of referral unless otherwise determined by the IEP/MP Care Coordinator.
2. Provision of this service must be of a time-limited basis and promote success in helping parents/legal guardians acquire the skills to help their student meet the goals and objectives in the student's IEP/MP.
3. Data will be kept for each session as to the progress made by parents/legal guardians receiving Parent Counseling/Training.
4. This service should be delivered in a setting that is best suited to address student's IEP/MP goals and objectives. This may occur at the student's school, home, or other site as identified by the team.
5. The counselor/trainer must integrate this service with other services, student's school, other agencies, and other DOE contracted providers.
6. The intent of this service is to realize reasonable benefit to the educational progress of the student.
7. The counselor/trainer shall provide the service in accordance with the time and frequency identified in the IEP/MP (e.g., do not provide all authorized contact hours for the month in one session at the end of the month, unless this arrangement is specified in the IEP/MP).

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

8. The parent's/legal guardian's inability to acquire the skills or knowledge, or lack of participation will result in the IEP/MP team revisiting the need for this service.
9. It is an expectation that contact be made with the school/teacher to develop the parent counseling/training plan within one week. After the plan is developed, the counselor/trainer will contact parent to initiate services. This inception date of services may be delayed as an accommodation to the parent, however, the counselor/trainer must provide notice of the delay to the DOE employee requesting the services in writing, email is acceptable.
10. Services shall be made available to parents/legal guardians within the typical workday as well as in the evening.
11. Initial appointment with student/family must be scheduled within two weeks of referral or per instructions of the IEP/MP Care Coordinator.
12. Written service plan is completed within one (1) week of referral, regularly reviewed, and updated.
13. Crisis plan is completed within one (1) week of referral, regularly reviewed, and updated.
14. Transition/Exit plans are completed, regularly reviewed, and submitted.
15. SBBH Quarterly Progress Report is completed according to service specifications.
16. Evidence of credentialing is available.

### **Documentation:**

Specific required documentation includes all of the following:

1. Develop and review a (written) service plan. The service plan must include specific concepts/skills in which education /training is being provided and data will be kept on progress or lack of progress in acquiring the specific concepts/skills identified. The Student Service Plan shall be turned in to the IEP/MP Care Coordinator within one (1) week of referral.
2. Contracted providers are required to utilize the specified Student Service Plan. See Appendix A-22. DOE employees shall ensure that the student has a service plan that includes all components of the Student Service Plan and may utilize the same or similar form.
3. Completion of visit records reflecting all contacts and entered into ISPED (or other designated database) within twenty-four (24) hours. Counselor/trainers shall input information in the ISPED (or other designated database) modules as may be required for each service description. Such information includes IEP/MP information, visit records, progress reports and other professional information or data that DOE may require.
4. By the 5<sup>th</sup> of every calendar month, input required data into ISPED (or other designated database) and the SBBH supplemental database, reporting on the student's end-of-month status, as well as service activities and student progress over the entire month. If the 5<sup>th</sup> falls on the weekend or a holiday, data input is due on the preceding school day.
5. SBBH Quarterly Progress Report and supporting shall be completed and made available to the student's IEP/MP Care Coordinator 2 weeks before the end of the quarter. Additionally, a report is due at the end of the ESY period if student is eligible. See Appendix A-19. The counselor/trainer will be responsible for providing measurable outcome data to assess the effectiveness of this service.
6. Tracking of outcome measures shall, at a minimum, include quarterly completion of the BASC-2 Student Observation System (SOS) in the setting of greatest difficulty, as well as, this data. Data shall be incorporated into the SBBH Quarterly Progress Report. The provider shall incorporate the contents of the SBBH Quarterly Progress Report into the ISPED (or other designated database) quarterly progress report.

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

### G. PSYCHIATRIC SERVICES

School-based behavioral health services are provided within the context of the Hawaii Department of Education Comprehensive Student Support System. As part of an integrated programmatic approach, these services are designed to provide the personalized support necessary to assist students to successfully engage in standards-based educational opportunities through overcoming individual barriers to learning. The primary goal is to remove barriers to learning through the provision of behavioral health services to students emphasizing the development of skills necessary to meet the social, communication, emotional and behavioral demands of the learning and school community environment.

Psychiatric evaluation and treatment services provided are to be integrated with DOE employee-provided or contracted behavioral health services in order to ensure timely and appropriate access to a full array of educational and behavioral health services that are organized in a coordinated and collaborative manner in an accountable, cost effective, performance-based system for providing services to assist all students.

### 1. PSYCHIATRIC DIAGNOSTIC EVALUATION

<b>Service Description</b>	<p>Psychiatric diagnostic examination, specifically completed by a licensed physician, involves a strengths-based approach to identify student's needs in the context of school, family and community. It includes history, mental status, physical evaluation and exchange of information with primary physician, student's disposition, a written assessment, and feedback to parent/family and IEP/MP development suggestions. This service is limited to an initial or follow-up evaluation for a <b>medically complex or diagnostically complex student</b>. This service does not involve ongoing psychiatric treatment or transfer of provider.</p> <p>Psychiatric diagnostic evaluation includes examination of a student and exchange of information with the primary care physician, and other informants such as family members and school staff, and the preparation of a report.</p>
<b>Services Offered</b>	<p>Psychiatric diagnostic evaluation shall include <u>all</u> of the following:</p> <ol style="list-style-type: none"><li>1. Review all previously collected data, including DOE reports, prior to interviewing student, family, and school staff.</li><li>2. Contact the family and arrange for appointment with the student and family within one week of procurement.</li><li>3. Initiate services within two weeks of procurement.<ol style="list-style-type: none"><li>a. Parental consent for assessment and release of information is covered by the IEP/MP consent. No additional parental consent for assessment or release is needed by the contracted provider.</li></ol></li></ol>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<ul style="list-style-type: none"><li>b. Review and incorporate reports completed by DOE professionals, including but not limited to psychometric test results, if available.</li><li>c. Review and incorporate any other relevant data including developmental, psycho-social, medical, educational, and legal histories as provided by the school student services coordinator (SSC).</li><li>d. Interview school personnel -- teachers, counselors, behavior specialists and/or administrators, or other persons that have first-hand knowledge of the functioning of the student.</li><li>e. Interview family/significant others.</li><li>f. Interview student face-to-face.</li></ul> <p>4. Submit completed written report to the DOE within 30 days of procurement. See Appendix A-15, Emotional Behavioral Assessment/Psychiatric Diagnostic Evaluation. A written report includes <u>all</u> of the following:</p> <ul style="list-style-type: none"><li>a. Date(s) of assessment and date of report.</li><li>b. Identifying information: student name, DOB, legal guardian, home-school, grade, IDEA/504 status.</li><li>c. Reason(s) for referral.</li><li>d. Sources of information: including review of records, interviews, and assessment tools.</li><li>e. Brief developmental, medical, family, social, educational, and psychiatric history-include past and current use of and reasons for psychotropic medications.</li><li>f. Substance use history.</li><li>g. Description and history of presenting problem(s).</li><li>h. Behavioral observations and Mental Status Exam must include <u>all</u> of the following:<ul style="list-style-type: none"><li>i. Appearance, attitude, and behavior;</li><li>ii. Orientation;</li><li>iii. Affect and mood;</li><li>iv. Thought content/processes:<ul style="list-style-type: none"><li>1. Fund of knowledge;</li><li>2. Intelligence;</li><li>3. Cognitive processes; and</li><li>4. Memory;</li><li>5. Insight;</li><li>6. Judgment; and</li><li>7. Homicidal/suicidal risk</li></ul></li></ul></li><li>i. Evaluation results and interpretation, which must include specific scores, plotted profiles, and</li></ul>
--	---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p>analytical interpretations of the Child and Adolescent Level of Care Utilization System (hereinafter "CALOCUS"), the Behavior Assessment System for Children, 2<sup>nd</sup> Edition, (hereinafter "BASC-2"), The Child &amp; Adolescent Functional Assessment Scale (hereinafter "CAFAS"), and Achenbach Checklists. The assessor must consider the BASC-2 data/reports and incorporate them in the evaluation/ recommendations.</p> <ul style="list-style-type: none"> <li>j. Student and Family Strengths.</li> <li>k. Clinical Formulation/Criteria of Diagnoses (include severity and duration of diagnoses; for Rule/Out or Provisional diagnoses, explain what needs to occur to obtain a more definite diagnosis).</li> <li>l. Diagnostic Impression: DSM IV-5 Axes.</li> <li>m. When medication is prescribed, the psychiatrist must obtain written formal consent from the parent/legal guardian and the student (if appropriate), after fully explaining the benefits, risks, and alternatives; and</li> <li>n. Psychiatric diagnostic evaluations shall be conducted with a student in a safe, and efficient manner in accordance with accepted standards for clinical practice.</li> <li>o. The written report shall address a student's needs and shall not specify a particular service, program, provider, or eligibility status. The IEP/MP Team determines whether a student needs a fully self-contained class, residential placement, at-home instruction, etc. All recommendations shall be supported by empirical research.</li> <li>p. Submitting completed written report within 30 days of procurement to the IEP/MP Care Coordination utilizing the Emotional Behavioral Assessment/Psychiatric Diagnostic Evaluation (See Appendix A -15).</li> <li>q. Provide information including signature, name and degree(s) of the evaluator, and the position and name of institution/organization of the evaluator is affiliated (if indicated and appropriate).</li> </ul>
<b>Target Population To Be Served</b>	<p>Students who are eligible for services described must meet the following criteria:</p> <ul style="list-style-type: none"> <li>1. The student has or is suspected of having a disability described in HAR Section 8-56-16 to 8-56-29 OR HAR Sections 8-53-1 to 8-53-38.</li> </ul>



## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<ol style="list-style-type: none"> <li>2. The student has an Individualized Educational Plan developed under criteria described in HAR Chapter 56, that is, a student is eligible for services under HAR Chapter 56 criteria and the student needs special education and related services because of the disability described in paragraph (1) above; or</li> <li>3. The student has a Modification Plan developed under criteria described in HAR Chapter 53, that is, a student is eligible for services under HAR Chapter 53 criteria and the student needs a modification plan and related services because of having a disability described in paragraph (1) above;</li> <li>4. The student resides in the State and comes within the following age range: (a) at least three years of age or (b) under twenty years on the first instructional day of the school year as set forth by the Department of Education; and</li> <li>5. The student is currently exhibiting moderate to severe social, communication, emotional or behavioral deficits and is in need of behavioral or mental health services, in order to benefit from his/her free and appropriate public education.</li> </ol>
<b>Referral Criteria</b>	<p>DOE Standards of Practice (SOP) have been followed and an SST/IEP or MP Team, in consultation with a DOE psychologist or SBBH supervisor, determines:</p> <ol style="list-style-type: none"> <li>1. The student with <b>medically complex or diagnostically complex needs</b> requires a comprehensive diagnostic evaluation to assist the team in designing interventions in emotional/behavioral crisis, exacerbations of behavioral symptoms, or serious and challenging behaviors; AND</li> <li>2. The student may need psychiatric intervention to augment IEP/MP related behavioral/mental health services to address behavioral/mental health needs; AND</li> <li>3. The student may need psychiatric intervention to treat an emotional-behavioral condition to prevent the need for a more restrictive or intensive service level.</li> </ol>
<b>Authorization</b>	<p>DOE Standards of Practice (SOP) and Procurement Procedures (PP) have been followed.</p> <p>Prior authorization via a completed procurement work order is required for each evaluation.</p> <p>The procured flat rate reflects the time required for completing the data gathering, assessment process, feedback session and final report. There is no payment for travel time, wait time, appointment no-shows, or cancellations.</p>

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

	Event is only billable upon completion of the evaluation and the report must be submitted to the appropriate school staff before submitting an invoice claim and before payment will be made.  Maximum Billable: Flat rate is required.
<b>Completion of Service</b>	The service is complete when all of the following steps are complete:  Step 1. The evaluation process has been completed; AND Step 2. The written evaluation report is submitted to the DOE and meets service specifications as set forth in the Service Description section, as described above. See Emotional Behavioral Assessment/Psychiatric Diagnostic Evaluation (See Appendix A-15). Evaluation reports not meeting these specifications will be returned to the assessor for correction. Payment may not be made or a reimbursement will be sought if the evaluation report is not corrected according to prescribed specifications.  Step 3. Feedback session of the evaluation results has been completed.

### Staffing Requirements:

1. Hawaii licensed physician and privileged through the provider's credentialing and privileging process to render diagnostic services;
2. Board Certified Child and Adolescent Psychiatry; or
3. APRN (see Glossary) who is working under the supervision of a licensed physician or psychiatrist meeting standards above.

### Documentation:

Written report shall be completed and submitted within thirty (30) days of procurement and shall document the nature, chronicity and severity of the disorder, DSM IV diagnosis, and recommendations including medication, utilizing the attached Emotional Behavioral Assessment/Comprehensive Psychiatric Diagnostic Evaluation (See Appendix A-15).

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

### 2. PSYCHIATRIC MEDICATION EVALUATION:

<b>Service Description</b>	<p>Psychiatric medication evaluation is specifically completed by a medical doctor, involves a strengths-based approach to identify student's needs in the context of school, family and community. It includes history, mental status, physical evaluation and exchange of information with primary physician, disposition, a written assessment, and feedback to parent/family and IEP/MP development suggestions. This service is diagnostic and assesses the student's presenting symptoms for the purpose of possible prescription and administration of medication by a physician. Previous emotional-behavioral or mental health assessments will be included in the referral packets. This service is limited to an initial evaluation and does not involve psychiatric treatment or medication management.</p> <p>Psychiatric medication evaluation includes examination of a patient and exchange of information with the primary care physician and other informants such as family members and school staff, and the preparation of a report.</p>
<b>Services Offered</b>	<p>Psychiatric medication evaluation includes <u>all</u> of the following:</p> <ol style="list-style-type: none"><li>1. Review all previously collected data, including DOE reports; prior to interviewing student and/or family and school staff</li><li>2. Contact the family and arrange for appointment with the student and family within one week of procurement;</li><li>3. Initiate service within two weeks of procurement:<ol style="list-style-type: none"><li>a. Administer assessment instruments and interpret assessment results; must include specific scores, plotted profiles, and analytical interpretations of the BASC-2, CAFAS, Achenbach Checklists, and CALOCUS.</li><li>b. Parent consent for assessment and release of information is covered by the IEP/MP consent. No additional parental consent for assessment or release is needed by the contracted provider.</li></ol></li><li>4. When medication is prescribed, the psychiatrist must obtain written formal consent from the parent/legal guardian and the student (if appropriate), after fully explaining the benefits, risks, and alternatives; and</li><li>5. Psychiatric medication evaluations shall be conducted with a student in a safe, and efficient manner in accordance with accepted standards for clinical practice.</li><li>6. The written report shall address a student's needs and shall not specify a particular service, program, provider, or eligibility status. The IEP/MP Team determines whether a student needs a fully self-contained class, residential placement, at-home instruction, etc. All recommendations shall be supported by empirical research.</li></ol>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<ol style="list-style-type: none"> <li>7. Submit the completed written report within 30 days of procurement to the DOE utilizing the Emotional Behavioral Assessment Annual Update /Psychiatric Medication Evaluation. See Appendix A-16.</li> <li>8. Provider information including signature, name and degree(s) of the evaluator, and the position and name of institution/organization of the evaluator is affiliated (if indicated and appropriate).</li> </ol>
<b>Target Population To Be Served</b>	<p>Students who are eligible for services described must meet the following criteria:</p> <ol style="list-style-type: none"> <li>1. The student has a disability described in HAR Section 8-56-16 to 8-56-29 OR HAR Sections 8-53-1 to 8-53-38;</li> <li>2. The student has an Individualized Educational Plan developed under criteria described in HAR Chapter 56, that is, a student is eligible for services under HAR Chapter 56 criteria and the student needs special education <b>and related services</b> because of the disability described in paragraph (1) above; or</li> <li>3. The student has a Modification Plan developed under criteria described in HAR Chapter 53, that is, a student is eligible for services under HAR Chapter 53 criteria and the student needs a modification plan <b>and related services</b> because of having a disability described in paragraph (1) above;</li> <li>4. The student resides in the State and comes within the following age range: (a) at least three years of age or (b) under twenty years on the first instructional day of the school year as set forth by the Department of Education; and</li> <li>5. The student is currently exhibiting moderate to severe social, communication, emotional or behavioral deficits and is in need of behavioral or mental health services, in order to benefit from his/her free and appropriate public education.</li> </ol>
<b>Referral Criteria</b>	<p>DOE Standards of Practice (SOP) (Appendix A-5i) have been followed and an SST/IEP or MP Team, in consultation with a DOE psychologist or SBBH supervisor, determines:</p> <ol style="list-style-type: none"> <li>1. Student has had a previous emotional/behavioral assessment and requires diagnostic evaluation; and</li> <li>2. The student may need psychiatric intervention to augment IEP/MP related behavioral/mental health services to address behavioral/mental health needs; and</li> <li>3. The student may need psychiatric intervention to treat an emotional-behavioral condition to prevent the need for a more restrictive or intensive service level.</li> </ol>
<b>Authorization</b>	<p>DOE Standards of Practice (SOP) (Appendix A-5i) and Procurement Procedures (PP) have been followed.</p>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

	<p>Prior authorization via a completed procurement work order is required for each evaluation.</p> <p>The procured flat rate reflects the time required for completing the data gathering, assessment process, feedback session and final report. There is no payment for travel time, wait time, appointment no-shows, or cancellations.</p> <p>Event is only billable upon completion of the evaluation and the report must be submitted to the appropriate school staff before submitting an invoice claim and before payment will be made.</p> <p>Maximum Billable: Flat rate is required.</p>
<b>Completion of Service</b>	<p>The service is complete when all of the following steps are complete:</p> <p>Step 1. The evaluation process has been completed; AND</p> <p>Step 2. The written evaluation report is submitted to the DOE and meets service specifications as set forth in the Service Description section, as described above. See Appendix A-16, Emotional Behavioral Assessment Annual Update/Psychiatric Medication Evaluation. Evaluation reports not meeting these specifications will be returned to the assessor for correction. Payment may not be made or a reimbursement will be sought if the evaluation report is not corrected according to prescribed specifications.</p> <p>Step 3. Feedback session of the evaluation results has been completed.</p>

### Staffing Requirements:

1. Hawaii licensed physician and privileged through the provider's credentialing and privileging process to render diagnostic services;
2. Board Certified Child and Adolescent Psychiatry; or
3. APRN (See Glossary ) who is working under the supervision of a licensed physician or psychiatrist meeting standards above.

### Documentation:

Written report shall be completed and submitted within 30 days of procurement and shall document the nature, chronicity and severity of the disorder, DSM IV diagnosis, and recommendations including medication, utilizing the attached Emotional Behavioral Assessment Annual Update/ Psychiatric Medication Evaluation. (See Appendix A-16.)

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### 3. MEDICATION MANAGEMENT:

<b>Service Description</b>	The ongoing assessment of the student's response to medication, symptom management, side effects, and adjustment in medication or dosage.
<b>Services Offered</b>	<p>Medication Management shall include all of the following:</p> <ol style="list-style-type: none"> <li>1. Assess the student's ongoing need for medication;</li> <li>2. Determine overt physiological effects related to the medications used in the treatment of the student's psychiatric condition, including side effects;</li> <li>3. Consult with parent and school regarding behavioral effects of medication;</li> <li>4. Determine psychological effects of medications used in the treatment of the student's psychiatric condition;</li> <li>5. Monitor compliance with prescription medication;</li> <li>6. Renew prescriptions;</li> <li>7. Documentation of informed consent, including a signed description of potential benefits and possible side effects of the prescribed medication, must be placed in the record prior to initiation of medication. The consent must be signed and dated by the student's parent/legal guardian; and</li> <li>8. Submit the written Psychiatric Medication Management Progress Note (See Appendix A-17 and Documentation section below).</li> </ol>
<b>Target Population To Be Served</b>	<p>Students who are eligible for services described must meet the following criteria:</p> <ol style="list-style-type: none"> <li>1. The student has a disability described in HAR Section 8-56-16 to 8-56-29 OR HAR Sections 8-53-1 to 8-53-38;</li> <li>2. The student has an Individualized Educational Plan; developed under criteria described in HAR Chapter 56, that is, a student is eligible for services under HAR Chapter 56 criteria and the student needs special education <b>and related services</b> because of the disability described in paragraph (1) above; or</li> <li>3. The student has a Modification Plan developed under criteria described in HAR Chapter 53, that is, a student is eligible for services under HAR Chapter 53 criteria and the student needs a modification plan <b>and related services</b> because of having a disability described in paragraph (1) above;</li> <li>4. The student resides in the State and comes within the following age range: (a) at least three years of age or (b) under twenty years on the first instructional day of the school year as set forth by the Department of Education; and</li> <li>5. The student is currently exhibiting moderate to severe social, communication, emotional or behavioral deficits and is in need of behavioral or mental health services, in order to benefit from his/her free and appropriate public education.</li> </ol>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

<b>Referral Criteria</b>	<p>DOE Standards of Practice (SOP) (Appendix A-5h) have been followed and based on the findings of the psychiatric evaluation, emotional/behavioral assessment and other educational data, the physician, psychiatrist, or APRN has determined:</p> <ol style="list-style-type: none"> <li>1. The student needs prescription and administration of medication to augment IEP/MP related behavioral/mental health services to address behavioral/mental health needs; and</li> <li>2. The student needs prescription and administration of medication to treat an emotional-behavioral condition to prevent the need for a more restrictive or intensive service level; and</li> <li>3. The student requires ongoing monitoring for effectiveness and adverse reactions to medications and for the renewing of prescriptions at frequencies consistent with accepted practice.</li> </ol>
<b>Verification of Service Session</b>	<p>DOE Standards of Practice (SOP) (Appendix A-5h) and Procurement Procedures (PP) have been followed.</p> <p>Prior authorization via a completed procurement work order is required quarterly.</p> <p>Prior procurement by DOE is required:</p> <ol style="list-style-type: none"> <li>1. Ongoing medication management requires discussion between the provider and the school personnel regarding the student's adjustment;</li> <li>2. Authorization guidelines are as follows: <ol style="list-style-type: none"> <li>a. DOE contemplates that the average session will take three (3) units to complete. Medication management is limited to 12 units per an episode;</li> <li>b. Medication management occurs at least monthly during the first three (3) months of initiation of any medication (and may occur more frequently if so documented by the treating physician); and</li> <li>c. At least, quarterly once the provider and the school document that the medications are effectively regulating the emotional-behavioral condition.</li> </ol> </li> <li>3. Provision of this service must be of a time-limited basis and based on evidence based instructional interventions conducive to reasonably achieving educational benefit;</li> <li>4. Additional units may be requested by the provider via the submittal of written specific justification of need. Written authorization must be obtained from the appropriate DOE District Educational Specialist.</li> </ol> <p>Maximum Billable: Limited to actual units utilized. (1 unit = 5 minutes, 12 units = 1 hour)</p>

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

<b>Verification of Service Session</b>	<ol style="list-style-type: none"><li>1. Service session is complete when the DOE specified Psychiatric Medication Monitoring Progress Note is placed within the student's agency record, with a copy sent to the IEP/MP care coordinator, within twenty (24) hours of the date of service;</li></ol> <p style="text-align: center;"><b>AND</b></p> <ol style="list-style-type: none"><li>2. The provider has completed the Service Verification Form See Appendix A-21).</li></ol>
<b>Exit Criteria</b>	<ol style="list-style-type: none"><li>1. The student's condition has stabilized and the symptoms have reduced in frequency and severity and medication has been discontinued;</li><li>2. The student and family no longer desire; psychopharmacological interventions and have withdrawn consent; or</li><li>3. The IEP/MP team determines the student no longer meets relevant eligibility criteria. As part of the transition, the physician will transfer the student to appropriate treatment services in the least disruptive manner possible, in a collaborative and coordinated manner.</li></ol>

### Staffing Requirements:

1. Hawaii licensed physician and privileged through the provider's credentialing and privileging process to render diagnostic services;
2. Board Certified Child and Adolescent Psychiatry; or
3. APRN (See Glossary) who is working under the supervision of a licensed physician or psychiatrist meeting standards above.

### Documentation:

Progress note must be placed within the student's agency record, with a copy sent to the IEP/MP care coordinator, within twenty-four (24) hours of the date of service, to include:

1. Name of student,
2. Date and actual time the services were rendered,
3. Place of service,
4. Dosage and intervals when medication is to be administered,
5. Side effects or adverse reactions that the student should be monitored for and the side effects or adverse reactions,
6. Conditions in which the student is refusing or unable to take medications as ordered or if the student is compliant in taking medications as prescribed, AND
7. Whether the medication is effectively controlling symptoms utilizing the Psychiatric Medication Management Progress Note. (See Appendix A-17.)



## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### H. INTENSIVE LEARNING CENTERS

<b>Service Description</b>	<p>An Intensive Learning Center is a program with a structured educational and therapeutic milieu with integrated educational and behavioral health services for students experiencing serious emotional/behavioral disturbances that interfere with their ability to function in a structured school classroom and places them at risk for more restrictive placements. The program will be a twelve (12) month program lasting at least six (6) hours per day, five (5) days a week, excluding observed DOE, State and Federal holidays. Educational components will be broad enough to meet each student's unique educational needs according to the IEP/MP goals/objectives.</p> <p>The intensity of the educational program in this setting will be sufficient to meet the student's needs without an extension of the school day, however, services must be available to accommodate any student with a need of extended school day/year programming should the IEP/MP team deem it necessary.</p>
<b>Services Offered</b>	<p>Intensive Learning Centers shall include all of the following:</p> <ol style="list-style-type: none"> <li>1. Specialized educational programming to address deficits in reading fluency and comprehension;</li> <li>2. Specially designed standards-based instruction to address the student's academic needs;</li> <li>3. Related services as required in student's IEP/MP;</li> <li>4. Functional Behavioral Assessment/Behavioral Support Plan reviewed at least quarterly;</li> <li>5. Evidence based individual/group interventions;</li> <li>6. Parent education/training;</li> <li>7. Medication Management, if needed;</li> <li>8. Long term and discharge transition planning:             <ol style="list-style-type: none"> <li>a. If the ILC is contracted, transportation to and from program site <b>may</b> be provided by the contracted provider. However, mid-day transportation needs <b>must</b> be provided by the contracted provider;</li> <li>b. Participation in internal reviews or service testing;</li> </ol> </li> <li>9. All curriculum and instructional materials and equipment, such as desks, computers and classroom supplies needed to implement the student's IEP/MP;</li> <li>10. Lunches and snacks which follow federally accepted nutritional guidelines; and</li> <li>11. If the ILC is contracted, transportation to and from program site <b>may</b> be provided by the contracted provider. However, mid-day transportation needs <b>must</b> be provided by the contracted provider.</li> </ol>
<b>Referral Criteria</b>	<p>DOE Standards of Practice (SOP) (Appendix A-5j) have been followed and the IEP/MP team has determined that:</p> <ol style="list-style-type: none"> <li>1. The student has or is suspected of having a disability described in HAR Section 8-56-16 to 8-56-29 OR HAR Sections 8-53-1 to 8-53-38;</li> </ol>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<ol style="list-style-type: none"> <li>2. The student has an Individualized Educational Plan developed under criteria described in HAR Chapter 56, that is, a student is eligible for services under HAR Chapter 56 criteria and the student needs special education and related services because of the disability described in paragraph (1) above; or</li> <li>3. The student has a Modification Plan developed under criteria described in HAR Chapter 53, that is, a student is eligible for services under HAR Chapter 53 criteria and the student needs a modification plan and related services because of having a disability described in paragraph (1) above; and</li> <li>4. The student resides in the State and comes within the following age range: (a) at least three years of age and (b) under 20 years on the first instructional day of the school year as set forth by the Department of Education; and</li> <li>5. The student is currently exhibiting severe social, emotional and behavioral deficits and is in need of behavioral or mental health services, as delineated in the IEP/MP goals and objectives, in order to benefit from his/her free and appropriate public education; and</li> <li>6. The student by the nature and severity of his/her disability requires unique and intensive educational programming; and</li> <li>7. The student is identified by their IEP/MP team as requiring highly specialized educational placement in a more restrictive setting beyond those usually available on a public school campus.</li> </ol>
<b>Authorization</b>	<p>DOE Standards of Practice (SOP) (Appendix A-5j) have been followed, and if procured, Procurement Procedures (PP) have been followed with integrity and the IEP/MP team agrees that child is at risk for a more restrictive placement.</p> <p>The program will be a twelve (12) month program lasting at least six (6) hours per day, five (5) days a week, excluding observed DOE, State and Federal holidays.</p> <p>Continuing placement is dependent on IEP/MP team agreement based on on-going progress monitoring data.</p>
<b>Monitoring Student Progress</b>	<p>The program staff shall:</p> <ol style="list-style-type: none"> <li>1. Collect daily data on each IEP/MP goal being addressed on that day. Licensed/certified program staff will aggregate and analyze the student's data and will provide written progress reports to student's IEP/MP care coordinator two weeks before the end of the quarter.</li> <li>2. Maintain and keep record of monthly communication with the school and/or district staff re: status of student.</li> <li>3. Schedule and convene quarterly meetings to review student status. Program staff will be responsible to invite DOE personnel such as the student's IEP/MP care coordinator,</li> </ol>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p>SPED and regular education teachers as appropriate, school administrator, other involved and appropriate agency staff, and student's parent if appropriate to each meeting. Cost accrued for these meetings are included as part of the program.</p> <ol style="list-style-type: none"> <li>4. Participate in a progress report meeting that will include parents and school representatives. The review will address at least the following: <ol style="list-style-type: none"> <li>a. Success of interventions;</li> <li>b. Anticipated alterations in interventions;</li> <li>c. Additional services;</li> <li>d. Interface with non-program provided interventions</li> <li>e. Long term view transition planning; and</li> <li>f. All agencies must participate in at least annually, and frequently quarterly contract monitoring. All documentation and all student records must be made available upon request by the DOE or for audits scheduled by DOE;</li> </ol> </li> <li>5. Track outcome measure, at a minimum, to include quarterly completion of BASC-2 Student Observation System (SOS) in the setting of greatest difficulty, as well as, this data. Data shall be incorporated into the SBBH Quarterly Progress Report. The provider shall incorporate the contents of the SBBH quarterly report into the ISPED (or other designated database) quarterly progress report.</li> </ol>
<b>Transitions/Exits</b>	<p>Transitions shall occur in accordance with the following steps:</p> <ol style="list-style-type: none"> <li>1. The IEP/MP team has met, reviewed student progress and determined that the exit criteria are met.</li> <li>2. The IEP/MP team reviewed the IEP/MP and revised it as needed.</li> <li>3. The IEP/MP team determined the placement should change.</li> <li>4. The program staff and DOE personnel collaboratively developed a transition plan to support the student's success in the less restrictive environment.</li> </ol> <p><b>There shall be NO exit without an IEP/MP change of placement decision.</b></p>
<b>Service Exclusions</b>	<p>ILC shall not be offered at the same time as Hospital-Based Residential Services, Community-Based Residential.</p>

### Staffing Requirements:

1. Qualified multidisciplinary staffing is available to address all educational, vocational, behavioral and emotional needs of the students.
2. The teacher must be licensed in Special Education. At a minimum, the teacher should have knowledge of and experience in educating students who exhibit severe social, emotional and behavioral deficits.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

3. Licensed related service providers in areas to include (but not limited to) Speech/ Language Pathologist, Occupational Therapists and others as identified in the IEP are available.
4. All paraprofessional staff must meet NCLB requirements.
  - a. Option 1 - 48 credits
    - Credits must be 100 level or higher in any subject area.
    - If earned after June 30, 2003, credits must include 3 credits in Math and 3 credits in English.
    - Must be earned from a regionally accredited institution.
    - Agencies must have all transcripts on file.
  - b. Option 2 - Associate's Degree
    - Degree must be earned with 100 level or higher courses.
    - For employees who earned a degree prior to January 8, 2002, the degree may include less than 100 level courses.
    - Must be earned from a regionally accredited institution.
    - Agencies must have all transcripts on file.
  - c. Option 3 – DOE compliance
    - Has met NCLB requirements under DOE guidelines and training.
5. Adequate staff to student ratio must be provided at all times to ensure safety for all activities and takes into consideration student characteristics. This is the total responsibility of the ILC program. Additional staff will not be provided by DOE.
6. Staff is available to ensure student safety for early arriving or late departing students.
7. To ensure appropriate family involvement, the agency (if contracted) is responsible for locating and providing interpreters for families whose limited English proficiency or mode of communication would inhibit their ability to meaningfully participate in the student's education.
8. All contract providers and agency staff members providing direct services must have attended, and have documented to the effect that he or she has completed at least forty (40) hours of annual professional development. Such professional development must be directly related to his or her work responsibilities.
  - a. Within the required forty hours of professional development, all contract providers and agency staff members must have at least forty (40) hours of basic training including, but not limited to, crisis field assessment and intervention, suicide assessment, risk assessment, clinical protocols, documentation, and knowledge of community resources, as well as training regarding court processes and legal documents relative to emergency procedures, plus specific legal issues governing informed consents. Such basic training must be completed prior to performing crisis outreach services.
  - b. All contract providers and agency staff members providing direct services must have at least twenty-four (24) hours of orientation completed before beginning service delivery. The consisted use of twenty-four (24) hours of orientation shall include:
    - IDEA and HAR Chapter 56 requirements, including procedures and eligibility criteria;
    - Family Educational Rights and Privacy Act and HAR Chapter 34 requirements;
    - An understanding of educationally relevant interventions and recommendations related to the target population; and
    - An understanding of applicable contract requirements.

*These twenty-four (24) hours can be applied towards the forty (40) hours of ongoing professional development required for the year*

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

### Service Operations:

1. Referral and Intervention Planning:
  - a. Program staff will be available to meet with school teams for consultation and information sharing.
  - b. Programs will accept students identified by Individualized Education Program/Modification Plan teams as meeting entrance requirements, with a no-rejection policy. The IEP/MP team will make any change in program and/or placement.
  - c. For Section 504 students, placement in the program should be temporary, term-limited intervention, with the goal of providing FAPE on a regular school campus, to allow appropriate access to the general education learning environment. Any placement decisions should be supported by a plan to transition the student back to a general education setting as soon as is appropriate.
  - d. Program staff will collaborate with DOE to develop an appropriate transition plan for entry/exit into the program no longer than a week after placement determination is made. At the same time, base line data will be reviewed and exit criteria determining student transition back to a less restrictive environment will be quantified. (Note: baseline student level data will at a minimum include the BASC-2.)
  - e. All referral materials, including functional behavior assessment and IEP/MP/behavior support plans will be reviewed with all staff expected to be involved in instruction or service provision.
  - f. Following student absences of three (3) consecutive days, program will contact student's family and document the reason for non-attendance. Program will contact student's home school to supply dates of absences and reasons. Prior to the 11<sup>th</sup> day that the student will be absent (cumulative per school year) program will notify student's home school and school administrator will determine if an IEP/MP meeting to review educational placement is needed.
  - g. When disciplining or suspending a student, program staff will follow Chapter 19 and Chapter 56 guidelines and report each occurrence to the respective school administrator and to the appropriate District Educational Specialist within twenty-four (24) hours.
2. Program Contents: Will be designed to address IEP/MP goals and objectives as well as specific referral concerns:
  - a. Academic Instruction
    - i. The program will implement the student's IEP/MP.
    - ii. The program will provide formative, remedial, or specialized instruction in reading to all students reading below grade level. In the event that a student's IEP/MP does not identify reading goals and objectives, they will be developed in collaboration with student IEP/MP team.
    - iii. The program will provide all educational information to the home school upon student's return so that all credits can be issued.
    - iv. State-wide assessments will be administered by DOE personnel at the program site within the testing window time frame, for each student in a benchmark year.
    - v. A standardized annual reading comprehension assessment will be completed by DOE personnel at the program site at least 90 days prior to each student's annual IEP/MP due date.
    - vi. Educational services shall be consistent with the Hawaii Content and Performance Standards II relevant to the ACCN credit desired. Documentation of the number of hours of instruction by course shall be available to the appropriate DOE school upon transition planning to assist in granting of academic credit to and the proper placement of the student.
    - vii. The program will hire and supervise its own educational staff, including certified special education teachers, related service personnel, and educational assistants.

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

- b. Positive Behavioral Support
  - i. Establish a classroom climate of “positive behavioral support” so that students achieve clearly delineated behavioral goals and objectives. The support program will be based upon a functional behavioral assessment including all behaviors necessitating an intervention of this restrictive nature, resulting in a behavioral support plan (BSP).
  - ii. The following forms of discipline are prohibited:
    - 1. Degrading punishment;
    - 2. Corporal or other physical punishment;
    - 3. Forced physical exercise solely for the purpose of eliminating behavior rather than for instructive or athletic value;
    - 4. Punitive work assignments;
    - 5. Group punishment for individual behavior;
    - 6. Medication for the purpose of punishment;
    - 7. Extended isolation of the student;
    - 8. Deprivation of student rights or needs;
    - 9. Painful aversive stimuli;
    - 10. Use of seclusion or mechanical restraints;
    - 11. Use of any locked facilities; and
    - 12. The administration of noxious substances.
- c. Medication and Medical Emergencies
  - i. The program is prepared to deal effectively with injuries, accidents, and illnesses and other medical and behavioral crises, as follows:
    - 1. Procedures for handling such situations have been developed in consultation with a health professional to protect the served students;
    - 2. Personnel involved in direct care are trained in basic first aid and retrained every three years;
    - 3. Personnel receive training in the identification of abuse and neglect and in mandated reporting requirements;
    - 4. One staff on duty is trained and currently certified in cardio-pulmonary resuscitation;
    - 5. Telephone, first aid supplies and manuals are readily available;
    - 6. Individual case records contain the names of family physician, clinic or hospital used in emergencies, and written authorization from the parent/legal guardian for emergency care; and
    - 7. Individual student records, including crisis management plans, are reviewed with all staff that interacts with applicable students.
  - ii. Establish emergency procedures and has either a licensed physician available on-call during its hours of operation or has formal arrangements for emergency services with a nearby primary health care facility.
  - iii. Promptly report any serious accident, emergency, or dangerous situation in writing to appropriate authorities. School staff will follow all mandated reporting of instances of suspected abuse. All reports would be sent to the respective school administrator and to the appropriate District Educational Specialist, utilizing the Sentinel Event / Incident Notification for DOE Contracted Providers form in Appendix A-20.
  - iv. The program assists student taking medications and establishes controls governing proper assistance and storage which include all of the following:
    - 1. Locked storage with supervision and access by only those staff trained and authorized;
    - 2. Proper labeling, with name of student, dosage, name of medication, and name of prescribing physician;

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

3. Destruction of out-of-date medication; and
  4. Proper disposal of unused medication, syringes, and medical waste.
  5. Provides for a safe physical environment.
- d. Interventions
- i. Evidence based interventions will be the primary mode of service delivery used to address student specific needs.
  - ii. If non-traditional interventions are used, a process to determine the appropriateness and effectiveness must be documented and available to school IEP/MP teams.
  - iii. Substance abuse treatment by appropriately credentialed staff will be available to students requiring such an intervention.
  - iv. Agency will provide any and all IDEA required related services, including but not limited to occupational therapy, physical therapy, speech, and transportation. In the event of a missed session of any IDEA required related service, please refer to the Procedures on Documenting Provision of Related Services document.

### Documentation

1. ILC staff shall input information into the ISPED (or other designated database) modules such as: 1) IEP/MP; 2) Visit Record; and 3) Progress Report and other modules that DOE may require. For any event in which work was done with the student, a visit record must be entered into ISPED (or other designated database) within 24 hours of its occurrence.
2. ILC staff shall provide written quarterly progress summary reports to the home school, utilizing the prescribed DOE format. Quarterly is defined in terms of the school year. The report must be submitted two weeks before the end of the quarter. Additionally, a report is due at the end of each ESY period for students who are eligible for this service during the ESY period. This will be subject to the use of ISPED, or another designated reporting system specified by the DOE.
3. A Student Service Plan shall be developed to include the student's IEP/MP goals/objectives, and all SBBH related sections of the Behavioral Support Plan. Additional plans specific to the individual provider's services to the student which are necessary to provide effective counseling and other SBBH services to address the student's goals and objectives should also be included.
4. Contracted providers are required to utilize the specified Student Service Plan. See Appendix A-22. DOE employees shall ensure that the student has a service plan that includes all components of the Student Service Plan and may utilize the same or similar form.
5. ILC staff shall Input report data into ISPED (or other designated database) and the SBBH supplemental database systems. Data to be inputted includes assessment data and other required data. By the 5<sup>th</sup> day of every calendar month, input required data into ISPED (or other designated database) and the SBBH supplemental database, reporting on end-of-month student status, as well as student progress and service activities over the entire month. If the 5<sup>th</sup> day falls on a weekend or holiday, data input will be due on the preceding school day.
6. Data entry into ISPED (or other designated database) (along with applicable requirements within each service activity) must be completed before invoice submission and payment.

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

PROGRAM	REPORT REQ'D	ISPED	HARD COPY
Intensive Learning Center	Quarterly Progress Reports	<i>yes</i>	<i>yes</i>
	SBBH Student Service Plan	<i>no</i>	<i>yes</i>
	Behavioral Support Plan	<i>no</i>	<i>yes</i>

### **ISPED (or other designated database) vs HARD COPY FORMATS:**

1. ILC staff must submit documentation and evidence of policies and procedures regarding sentinel events and incidents. At a minimum, these policies should address (1) how the program will notify the respective school administrator and the appropriate District Educational Specialist within 24 hours by fax or phone and in writing within 72 hours of any event that compromises the safety of a student; (2) how the program tracks the occurrence of all sentinel events and incidents to identify trends and patterns in order to implement improvements; and (3) a complete analysis of the event as well as actions taken to address the event.
2. ILC staff must submit documentation and evidence of policies and procedures regarding the use of restraints to SBBH DES.

The DOE reserves the right to evaluate the program/service delivery for program monitoring purposes on an annual basis, at a minimum, through either an on-site evaluation or a documentation review.



## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### I. INTENSIVE SERVICES

#### 1. INTENSIVE INSTRUCTIONAL SERVICES CONSULTATION:

Department of Education (DOE) personnel, to include but not limited to: Special Education Teachers, Special Education Resource Teachers, Behavioral Specialists and Speech Language Pathologists are deemed qualified to provide the following services. When the DOE does not have the personnel capacity to provide the following services the DOE will then contract using the following criteria:

<b>Service Description</b>	<p>The purpose of Intensive Instructional Services Consultation is to:</p> <ul style="list-style-type: none"><li>• Lead and direct the activities of paraprofessionals when DOE personnel is unavailable to do so; or</li><li>• Lead and direct the activities of paraprofessionals working with a group when DOE personnel are unavailable to do so.</li></ul> <p>The procurement of an Intensive Instructional Services Consultant (IISC) should be considered an intensive intervention. Its primary expectation is to design strategies that will promote growth toward meeting identified educational goals of a student with a combination of severe social, communication and behavioral deficits. It is a requirement that the IISC is established as a professional and be fully competent in their ability to implement this service through the credentialing, training, or oversight by the agency. IISCs must understand how to support differentiated curricula adapted to the social, communicative and behavioral needs of students. At a minimum, an IISC should have knowledge of, and experience, using evidence based instructional interventions including but not limited to applied behavioral analysis principles, discrete trial teaching, functional visual communication systems, structured teaching approaches and typical child development. Any additional training or consultative support needed by an IISC to support an individual student will be available from the agency's supervisory and training infrastructure and shall be provided by the agency as an included cost of the service and provided prior to the IISC beginning work activities.</p>
<b>Services Offered</b>	<p>Any IISC shall work collaboratively with the classroom teacher and all other members of a student's educational team.</p> <p>The IISC will contact the teacher to collaborate in developing the service plan within one week of procurement. The provider will submit the service plan to the teacher within two weeks of procurement. See Student Service Plan in the Appendix A-22.</p> <p>As many students exhibiting a combination of severe social, communication and behavioral deficits require accommodations for access to their educational curriculum, IISCs may be required to develop schedules, work systems, visual cues, communication books and other accommodations to promote access to the curriculum. This is to be considered an included cost of the service.</p>

	<p><b>A. Lead and Direct a Paraprofessional (Individual student support)</b></p> <p>After collaboration with the classroom teacher, the IISC will develop a written service plan that details the skills to be reinforced, the instructional strategies to be utilized across domains and the data management strategy to be implemented on a day-to-day basis. The service plan must detail how skills taught by DOE professional personnel would be reinforced and generalized. The service plan must follow the IEP/MP goals and objectives as identified by the DOE. If there is a difference of opinion about the service plan, the classroom teacher has the final determination. Monitoring of progress on the plan must be coordinated with the classroom teacher as an ongoing consultative process which includes meetings with the appropriate school personnel to discuss specific issues/interventions related to student performance. The amount of service will be limited to the hours outlined in the IEP/MP. The need for this service under this contract will be generated upon DOE request and may transfer to DOE personnel as the resources become available.</p> <p>Due to the restrictive nature of individual student support, it is anticipated that this service focuses on increasing student's ability to access educational supports in a group setting as quickly as is appropriate for the student.</p> <p><b>B. Lead and Direct a Paraprofessional</b></p> <p>If the IISC is leading and directing a paraprofessional(s) working with a group of students, the IISC will develop a service plan that will identify how the group activities will address each student's identified individual IEP/MP goals and objectives as an extension of the activities that are initiated in the DOE program. For example:</p> <p style="padding-left: 40px;"><i>On Tues. students will play a board game and make popcorn. Student A and B will work on turn taking. Student C and D will work on initiating peer interactions. "Would you like some pop corn?" "Your turn," "My turn," etc.</i></p> <p>The group service plan will detail the skills to be reinforced, the instructional strategies to be utilized and the data management strategy to be implemented on a day-to-day basis (See Appendix A-22). Data will be kept on each goal and objective worked on during the group session for each student. Activities will be appropriate to the student's age and developmental level. Groups will be made up of students who are age and developmentally compatible. Monitoring of progress on the plan must be coordinated with the classroom teacher as an ongoing consultative process which includes meetings with the appropriate school personnel to discuss specific issues/interventions related to student performance.</p>
--	---

**C. Guidelines for IISC Leading and Directing  
Paraprofessional(s) Individual and Group Settings:**

The functions of the IISC are to develop a service plan, to ensure that data collection is completed and to coordinate with the DOE team.

For IISC individual and group, the service plan will be implemented by a paraprofessional and monitored by the IISC or designated DOE personnel. If necessary, the IISC will provide direct instruction/training to the paraprofessional in the implementation of the service plan. It is expected that this training will include intermittent observation of the paraprofessional while implementing the plan with the student. The IISC must provide direction to the paraprofessional personnel over the course of the intervention. The IISC must meet at least one hour a month with the paraprofessionals for client specific group supervision. Case reviews must be a part of this supervision hour.

If the IISC has concerns about the direction from the classroom teacher, the IISC is to inform their agency supervisor who shall first bring the matter to the school administrator. Should the matter be unresolved at the school level, the agency supervisor shall contact the appropriate District Educational Specialist.

For any of the services listed above, the provider must deliver the service in the time and frequency identified in the IEP/MP (e.g., do not provide all authorized contact hours for the month in one session at the end of the month, unless this arrangement is specified in the IEP/MP). Any missed hours by the IISC will be reported to the school administrator or designee. See Section 5, Attachment G.

The IISC will monitor the data gathered on the student's progress toward (or lack thereof) on the specified IEP/MP goals and objectives. The IISC will evaluate the data with the classroom teacher to determine necessary instructional modifications. Monitoring of progress on the plan must be coordinated with the classroom teacher as an ongoing consultative process which includes meetings with the appropriate school personnel to discuss specific issues/interventions related to student performance. The amount of service will be limited to the hours outlined in the IEP/MP. The need for this service under this contract will be generated upon DOE request and may transfer to DOE personnel at the discretion of the DOE.

Progress towards the IEP/MP goals and objectives is expected to result in a shift in support to promote independence and a reduction in the need for these services. Lack of student progress will be discussed with the classroom teacher. The IISC, in

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

	<p>collaboration with the classroom teacher, will revise the service plan to promote progress.</p> <p>IISC providers must have the ability to deliver services in various environments, such as schools, homes (birth, kin, adoption, and foster), community, homeless shelters, street locations, etc.</p> <p>Services should be delivered in a setting determined by the DOE. This may occur at the school, student's home, or at a site in the student's home community as identified by the team. Sites will be appropriate to the student's age and developmental level. The provider must integrate this service with other agencies, and other DOE contracted providers.</p> <p>Should interventions occur outside of school, they must provide repetition and generalization of skills learned in the classroom. For all services provided in private homes, a parent, guardian or caregiver (must be at least 18 years of age) will be present for the duration of the session. An IISC, ST or any other DOE contracted provider is not considered a parent, guardian or caregiver.</p> <p>Under the terms and conditions of this RFP, the DOE will not pay an agency for transportation costs or reimbursement for mileage.</p> <p>Teaming and collaboration among all instructional team members is critical in the development and implementation of appropriate educational services for a student such as those that are exhibiting a combination of severe social, communication and behavioral deficits. To that extent, it is a recommendation that the paraprofessional and IISC be affiliated with the same provider agency, if both services are being procured. This is to help ensure clear communication and coordination between these two services. In the event that it is not possible to meet the instructional needs of a student via one provider agency, the School Administrator will identify the roles of all parties. If there are paraprofessionals from multiple agencies, the IISC is responsible for communicating with each of the paraprofessional's supervisors.</p> <p>The agency shall adopt and implement policies and procedures that govern the provision of services in natural settings and document that it respects students' and/or families' right to privacy when services are provided in these settings. The DOE shall have the right to inspect and approve these policies. The agencies records relating to students under this contract are governed under FERPA. The documents and records held by the agency for students serviced under this contract are the property of DOE.</p> <p><b>If the DOE requires the IISC to attend an IEP/MP meeting for the student, authorization must come from a DOE administrator affiliated with the IEP/MP team and be billed under Educational Team Planning Participation.</b></p>
--	--

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

<b>Authorization</b>	<p>DOE Standards of Practice (SOP) have been followed, and if procured, Procurement Procedures (PP) have been followed.</p> <ol style="list-style-type: none"><li>1. The following activities are to be considered billable events:<ul style="list-style-type: none"><li>• Leading and directing the activities of the paraprofessional when DOE personnel is unavailable to do so; and/or</li><li>• Leading and directing the activities of paraprofessional(s) working with a group when DOE personnel are unavailable.</li></ul><p><b>All hours billable in the above activities will be per the student's IEP/MP.</b></p></li><li>2. The following activities are not considered to be billable events:<ul style="list-style-type: none"><li>• Phone contact for the purposes of IISC service;</li><li>• Scheduling consultation hours;</li><li>• Missed hours;</li><li>• Travel time;</li><li>• Unscheduled, anecdotal conversations, even if it is student centered;</li><li>• Unauthorized hours, hours outside of the IEP/MP designated hours or retroactive hours;</li><li>• Any team meeting at which the DOE has not requested or required providers attendance;</li><li>• Any team meeting in which DOE is not present;</li><li>• Any activity that is not educationally related and specifically addresses targeted IEP/MP goals and objectives;</li><li>• Consultation about or leading and directing paraprofessionals in any methodology that is not evidence based to address severe social, communicative and behavioral deficits and not developmentally appropriate;</li><li>• Corrections to reports or documents that the DOE identified as inadequate;</li><li>• Documentation associated with consultation and leading and directing paraprofessionals;</li><li>• Activities such as the development/adjusting of the service plan; collecting, aggregating and analyzing data; preparing quarterly progress reports; or developing/preparing materials; and</li><li>• Specific skill building for the paraprofessional, such as exposure to specific methodology needed to support a student. This is part of the agency's training responsibility that must be completed prior to the paraprofessional being assigned to a child.</li></ul></li></ol>
----------------------	---

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

<b>Referral Criteria</b>	<p>The DOE determines the following:</p> <ul style="list-style-type: none"><li>• The DOE does not have the capacity to lead and direct the activities of a paraprofessional working with an individual student; or</li><li>• The DOE does not have the capacity to lead and direct the activities of paraprofessional(s) working with a group.</li></ul> <p>For Section 504 students, intensive services should be temporary, term-limited intervention, with the goal of providing FAPE on a regular school campus, to allow appropriate access to the general education learning environment. Any intensive service provision should be supported by a plan to transition student back to a general education setting as soon as is appropriate.</p>
<b>Completion of Service</b>	<ol style="list-style-type: none"><li>1. DOE determines the service of the provider is no longer necessary; and/or</li><li>2. The student has met the objectives identified at the initiation of the service; and/or</li><li>3. The student has reached mastery level on their IEP/MP goals and objectives identified for this service; and/or</li><li>4. The student has not made measurable gains for one or more quarters of this service provision; and/or</li><li>5. The student's IEP/MP team determined that the provision of this service is no longer needed.</li></ol>

### Staffing Requirements:

1. Skills Trainers must receive a minimum of one hour of client-specific group supervision each month. Case reviews must be a part of each supervision hour.
8. At a minimum, Skills Trainer must have a two-year degree from an accredited university or institution of higher learning or meet Federal No Child Left Behind (NCLB) requirements. Any additional training should be available from the agency's supervisory and training infrastructure. NCLB requirements are:
  - a. Option 1 - 48 credits
    - Credits must be 100 level or higher in any subject area.
    - If earned after June 30, 2003, credits must include 3 credits in Math and 3 credits in English.
    - Must be earned from a regionally accredited institution.
    - Agencies must have all transcripts on file.
  - b. Option 2 - Associate's Degree
    - Degree must be earned with 100 level or higher courses.
    - For employees who earned a degree prior to January 8, 2002, the degree may include less than 100 level courses.
    - Must be earned from a regionally accredited institution.
    - Agencies must have all transcripts on file.
  - c. Option 3 – DOE compliance
    - Has met NCLB requirements under DOE guidelines and training.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

9. **Provider agencies** will be responsible for providing replacement staff for absences or vacations of the assigned skills trainer(s). It is expected that a pool of substitutes will be maintained to ensure continuity of service delivery. Failure to provide a replacement Skills Trainer either on a temporary or permanent basis shall be documented and may impact future contract awards.

### Documentation

1. Prior to initial service contact, the Skills Trainer should have the service plan provided by the classroom teacher. In the case where the Skills Trainer has no contact with the classroom teacher, the IISC will provide the service plan to the Skills Trainer. It will also include a plan to monitor progress and will describe the level and intensity that will be provided by the Skills Trainer as well as the proposed plan to adjust the levels and intensity of assistance provided by the Skills Trainer.
2. Skills Trainers will collect daily data on each IEP/MP goal and objective for which the Skills Trainer is responsible for implementing on that day. This data must relate to the directions set forth in the service plan. The Skills Trainer will give the data to the classroom teacher or the IISC, if procured, on a weekly basis or as otherwise *arranged*. No additional time may be billed for corrections. In the event that the Skills Trainers has no contact with the classroom teacher, the IISC is responsible for getting the data to the classroom teacher on a weekly basis.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### 2. PARENT EDUCATION/TRAINING

Department of Education (DOE) personnel, to include but not limited to: Special Education Teachers, Special Education Resource Teachers, Behavioral Specialists and Speech Language Pathologists are deemed qualified to provide the following services. When the DOE does not have the personnel capacity to provide the following services the DOE will then contract using the following criteria:

<b>Service Description</b>	The purpose of Parent Education/Training is to educate parents or legal guardians (with whom the student resides) in understanding the special needs of their child who is exhibiting severe social, communication, and behavioral deficits, and help parents to acquire and practice the skills that will allow them to support educational progress. Topics of instruction may include, but are not limited to information related to their child's disability and related diagnosis; techniques to address behavioral issues; information about evidence based strategies.
<b>Services Offered</b>	<p>Provision of this service must be of a time-limited basis and promote success in helping parents acquire the skills to support their student's educational progress. A parent training plan will be developed by DOE personnel or the parent trainer in collaboration with the classroom teacher based on topics that address the training needs of the parent as identified by the IEP/MP team. Data will be kept as to the progress made by parent receiving Parent Education/Training at each session.</p> <p>The intent of this service is to enable the parent to help support their child's educational progress. The provider shall provide the service in the time and frequency identified in the IEP/MP (e.g., do not provide all authorized contact hours for the month in one session at the end of the month, unless this arrangement is specified in the IEP/MP). The parent's inability to acquire the skills or knowledge or lack of participation will result in the IEP/MP team revisiting the need for this service.</p> <p>It is an expectation that contact be made with the school to develop the parent training plan within one week of procurement. After the training plan is developed, the parent trainer will contact parent to initiate services. This inception date of services may be delayed as an accommodation to the parent, however, the provider must provide notice to the DOE employee requesting the services in writing, e-mail is acceptable.</p> <p>Services are available to parents within the typical workday as well as in the evening.</p> <p>This service should be delivered in a setting determined by the DOE. This may occur at the student's school, home, or other site as identified by the team. The provider should be able to integrate this service with other services, school, agencies, and other DOE contracted providers.</p>



---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

	<p>Under the terms and conditions of this RFP, the DOE will not pay an agency for transportation costs including reimbursement for mileage.</p> <p>The agency shall adopt and implement policies and procedures that govern the provision of services in natural settings and documents that it respects students' and/or families' right to privacy when services are provided in these settings. The DOE shall have the right to inspect these policies. Educational records are governed under FERPA; these documents are the property of DOE.</p>
<b>Authorization</b>	<p>DOE Standards of Practice (SOP) (Appendix A-5e) have been followed, and if procured, Procurement Procedures (PP) have been followed.</p> <p>A billable event consists of face-to-face contact with persons who are the recipient of the training. Any reporting or documentary requirements should be considered an included cost. Phone contact should not be considered a billable event. Absence of the training report will be constructive proof that the event did not occur and the amount billed subject to refund.</p>
<b>Referral Criteria</b>	<ol style="list-style-type: none"><li>1. Training plan has been implemented and completed; and/or</li><li>2. DOE resources are available to provide the service; and/or</li><li>3. The IEP/MP team determined that the provision of this service is no longer needed.</li></ol>

### Staffing Requirements:

1. The agency must provide adequate supervision of a Parent Education/Training provider and shall minimally consist of two hours per month - one hour of individual and one hour of group supervision that is to be documented in their personnel file. See definition of "adequate supervision" on page 2-8.
2. Supervision of a parent trainer shall consist of case review minimally two hours per month; one hour of individual and one hour of client-specific group supervision each month that is documented in their personnel file.
3. At a minimum, Parent Education/Training providers must possess:
  - a. A Doctorate degree in special education, speech and language pathology, occupational therapy, psychology, psychiatry, and social work and two years direct experience working with a variety of students who are exhibiting severe social, communication and behavioral deficits.

**OR**

  - b. A Masters degree in special education, speech and language pathology, occupational therapy, psychology, or social work and three years of direct experience working with a variety of students who are exhibiting severe social, communication and behavioral deficits.

**OR**

  - c. A Bachelors degree in special education, speech and language pathology, occupational therapy, psychology, social work and five years direct experience working with a variety of students who are exhibiting severe social, communication and behavioral deficits.

## **INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES**

---

### **Documentation:**

1. Prior to initial service contact, the service provider should have written information provided by DOE personnel in regards to which specific concepts/skills a parent is receiving training.
2. Parent Training plan must include specific concepts/skills in which training is being provided and data will be kept on progress or lack of progress in acquiring the specific concepts/skills identified.
3. A training report and supporting data is to be provided to IEP/MP CC monthly. See Section 5, Attachment I. Contracted agencies will be responsible for providing measurable outcome data to assess the effectiveness of this service. Absence of the training report and data will be constructive proof that the event did not occur and the amount billed subject to refund.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### J. SPECIAL SCHOOL

When the Department of Education (DOE) does not have the personnel capacity to provide the following services the DOE will then contract using the following criteria:

<b>Service Description</b>	<p>The purpose of the Special School is to provide a public separate facility for students in need of a more restrictive setting than is usually available on a public school campus. The outcome of a separate facility placement is to provide the LRE for students who are unable to receive FAPE on a public school campus yet do not require a more restrictive setting such as residential or homebound setting.</p> <p>There are two basic goals for students who receive their education at the Special School:</p> <ol style="list-style-type: none"><li>1. Provide an appropriate educational program including all specially designed instruction and related services so that the student meets their annual IEP/MP goals and objectives.</li><li>2. Provide individualized supports to enable the student to return to a less restrictive environment.</li></ol>
<b>Services Offered</b>	<p>It is expected that the Special School program will be based on the Hawaii State Content and Performance Standards II and best practice educational and behavioral approaches in educating students with severe disabilities. The special school curriculum and methodology will be selected so that it articulates with the home school educational program. This will ensure smooth transition in and out of the special school. The special school supports will adhere to the student's IEP/MP. Provision of services is intended to enable the student to meet his/her annual goals and objectives on the student's IEP/MP.</p> <ol style="list-style-type: none"><li>1. Referral and Intervention Planning<ol style="list-style-type: none"><li>a. Program staff will be available to meet with school teams for consultation and information sharing.</li><li>b. Programs will accept students identified by IEP/MP teams as meeting entrance requirements, with a no-rejection policy. The IEP/MP team will make any change in program and/or placement.</li><li>c. For Section 504 students, placement in the program should be temporary, tern-limited intervention, with the goal of providing FAPE on a regular school campus, to allow appropriate access to the general education learning environment. Any placement decisions should be supported by a plan to transition the student back to a general education setting as soon as is appropriate.</li><li>d. Program staff will collaborate with DOE to develop an appropriate transition plan for entry/exit into the program no longer than one week after placement determination is made. At the same time, base line data will be reviewed and exit criteria determining</li></ol></li></ol>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p>student transition back to a less restrictive environment will be quantified.</p> <ul style="list-style-type: none"><li>e. All referral materials, including functional behavioral assessment and IEP/MP behavior support plans will be reviewed with all staff expected to be involved in instruction or service provision.</li><li>f. Following student absences of three (3) consecutive days, program will contact student's family and document the reason for non-attendance. Program will contact student's home school to supply dates of absences and reasons. Prior to the 11<sup>th</sup> day that the student will be absent (cumulative per school year) program will notify student's home school, and school administrator will determine if an IEP/MP meeting to review educational placement is needed.</li><li>g. When disciplining or suspending a student, program staff will follow Chapter 19 and Chapter 56 guidelines and report each occurrence to the respective school administrator and appropriate district educational specialist within 24 hours.</li></ul> <p>2. Program contents: Will be designed to address IEP/MP goals and objectives as well as specific referral concerns</p> <ul style="list-style-type: none"><li>a. Academic instruction<ul style="list-style-type: none"><li>i. The program will implement the student's IEP/MP.</li><li>ii. The program will provide specialized instruction in all academic areas appropriate to the student's age and developmental level.</li><li>iii. The program will provide all educational information to the home school upon student's return so that all credits can be issued.</li><li>iv. Statewide assessments will be administered by DOE personnel at the special school site within the testing window time frame, for each student in a benchmark year.</li><li>v. A standardized annual reading comprehension assessment will be completed by DOE personnel at the special school site at least 90 days prior to each student's annual IEP/MP due date.</li><li>vi. Educational services shall be consistent with the Hawaii Content and Performance Standards II relevant to the ACCN credit desired. Documentation of the number of hours of instruction by course shall be available to the appropriate DOE school upon transition planning to assist in granting of academic credit to and the proper placement of the student.</li><li>vii. The program will hire and supervise educational staff, including certified special education</li></ul></li></ul>
--	---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p>teachers, related service personnel and educational assistants.</p> <ul style="list-style-type: none"><li>b. Positive Behavioral Support<ul style="list-style-type: none"><li>i. Establish a classroom climate of “positive behavioral support,” so that students achieve clearly delineated behavioral goals and objectives. The support program will be based upon a functional behavioral assessment including all behaviors necessitating an intervention of this restrictive nature, resulting in a behavioral support plan (BSP).</li><li>ii. The following forms of discipline is prohibited:<ul style="list-style-type: none"><li>1. Degrading punishment;</li><li>2. Corporal or other physical punishment;</li><li>3. Forced physical exercise solely for the purpose of eliminating behavior rather than for instructive or athletic value;</li><li>4. Punitive work assignments;</li><li>5. Group punishment for individual behavior;</li><li>6. Medication for the purpose of punishment;</li><li>7. Extended isolation of the student;</li><li>8. Deprivation of student rights or needs;</li><li>9. Painful aversive stimuli;</li><li>10. Use of seclusion or mechanical restraints;</li><li>11. Use of any locked facilities; and</li><li>12. The administration of noxious substances.</li></ul></li></ul></li><li>c. Medication and Medical Emergencies<ul style="list-style-type: none"><li>i. The special school is prepared to deal effectively with injuries, accidents, and illnesses and other medical and behavioral crises, as follows:<ul style="list-style-type: none"><li>1. Procedures for handling such situations have been developed in consultation with a health professional to protect the served students;</li><li>2. Personnel involved in direct care are trained in basic first aid and retrained every three years;</li><li>3. Personnel receive training in the identification of abuse and neglect and in mandated reporting requirements;</li><li>4. One staff member on duty is trained and currently certified in cardio-pulmonary resuscitation;</li><li>5. Telephone, first aid supplies and manuals are readily available;</li><li>6. Individual case records contain the names of family physician, clinic or hospital used in emergencies, and written authorization from the parent/legal guardian for emergency care; and</li></ul></li></ul></li></ul>
--	--

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<ul style="list-style-type: none"> <li>7. Individual student records, including crisis management plans, are reviewed with all staff that interacts with applicable students.</li> <li>ii. Establish emergency procedures and has either a licensed physician available on-call during its hours of operation or has formal arrangements for emergency services with a nearby primary health care facility.</li> <li>iii. Promptly report any serious accident, emergency or dangerous situation in writing to appropriate authorities. School staff will follow all mandated reporting of instances of suspected abuse. All reports will be sent to the respective school administrator and to the appropriate district educational specialist (See Appendix A-20).</li> <li>iv. The Special School assists student taking medications and establishes controls governing proper assistance and storage which include <u>all</u> of the following:               <ul style="list-style-type: none"> <li>1. Locked storage with supervision and access by only those staff trained and authorized;</li> <li>2. Proper labeling, with name of student, dosage, name of medication, and name of prescribing physician;</li> <li>3. Destruction of out-of-date medication; and</li> <li>4. Proper disposal of unused medication, syringes, and medical waste.</li> </ul> </li> <li>v. Provides for a safe physical environment.</li> <li>d. Interventions               <ul style="list-style-type: none"> <li>i. Evidence based interventions will be the primary mode of service delivery used to address student specific needs,</li> <li>ii. Agency will provide any and all IDEA required related services, including but not limited to occupational therapy, physical therapy, speech therapy and transportation except to and from program. In the event of a missed session of any IDEA required related service, please refer to the <u>Procedures on Documenting Provision of Related Services</u> document.</li> </ul> </li> </ul>
<b>Monitoring Student Progress Criteria</b>	<ul style="list-style-type: none"> <li>1. Special school staff will schedule and complete monthly meetings for each student to review student status. Special school staff will be responsible to invite DOE personnel such as the student's IEP/MP care coordinator, SPED and regular education teachers as appropriate, school administrator, and student's parent if appropriate to each meeting. Costs accrued for these meetings are included as part of the program.</li> </ul>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<ol style="list-style-type: none"> <li>2. School staff will collect daily data on each IEP/MP goal being addressed on that day. Licensed/Certified school staff will aggregate and analyze the student's data and will provide written progress reports to student's IEP/MP care coordinator two weeks before the end of the quarter.</li> <li>3. The special school staff will participate in a progress report meeting that will include the parents and school representatives. The review will address at least the following: <ol style="list-style-type: none"> <li>a. Specific level of student current functioning</li> <li>b. Review of data</li> <li>c. Review of exit criteria</li> </ol> </li> <li>4. All agencies must participate in at least annually, and frequently quarterly contract monitoring. All documentation and all students' records must be made available upon request by the DOE or for audits scheduled by DOE.</li> </ol>
<b>Authorization</b>	<p>DOE Standards of Practice (Appendix A-5k) and Procurement Procedures have been completed with integrity and the IEP/MP team agrees that child is at risk for a more restrictive placement.</p> <p>The program will be a twelve (12) month program lasting at least six (6) hours per day, five (5) days a week, excluding observed DOE, State and Federal holidays.</p> <p>Continuing placement is dependent on IEP/MP team agreement based on on-going progress monitoring data.</p>
<b>Referral Criteria</b>	<ol style="list-style-type: none"> <li>1. The student has or is suspected of having a disability described in HAR Section 8-56-16 to 8-56-29 OR HAR Sections 8-53-1 to 8-53-38;</li> <li>2. The student has an Individualized Educational Plan developed under criteria described in HAR Chapter 56, that is, a student is eligible for services under HAR Chapter 56 criteria and the student needs special education and related services because of the disability described in paragraph (1) above; or</li> <li>3. The student has a Modification Plan developed under criteria described in HAR Chapter 53, that is, a student is eligible for services under HAR Chapter 53 criteria and the student needs a modification plan and related services because of having a disability described in paragraph (1) above; and</li> <li>4. The student resides in the State and comes within the following age range: (a) at least three years of age and (b) under 20 years on the first instructional day of the school year as set forth by the Department of Education; and</li> <li>5. The student is currently exhibiting severe social, emotional and behavioral deficits and is in need of behavioral or mental health services, as delineated in the IEP/MP goals</li> </ol>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p>and objectives, in order to benefit from his/her free and appropriate public education; and</p> <ol style="list-style-type: none"> <li>6. The student by the nature and severity of his/her disability requires unique and intensive educational programming; and</li> <li>7. The student is identified by their IEP/MP team as requiring highly specialized educational placement beyond those available on a public school campus.</li> </ol>
<b>Transitions/Exit</b>	<p>Transitions will occur in accordance with the following steps:</p> <ol style="list-style-type: none"> <li>1. The IEP/MP team has met, reviewed student progress and determined that the exit criteria are met.</li> <li>2. The IEP/MP team reviewed the IEP/MP and revised it as needed.</li> <li>3. The IEP/MP team determined that placement should change.</li> <li>4. Special school staff and DOE personnel collaboratively developed a transition plan to support the student's success in the less restrictive environment.</li> <li>5. <b>There will be no exit without an IEP/MP change of placement decision.</b></li> </ol>

### Staffing Requirements:

1. Qualified multidisciplinary staffing is available to address all educational, social, behavioral and communication needs of the students
2. The teacher is licensed in Special Education with training in educating students who exhibit a combination of severe social, communication and behavioral deficits. At a minimum the teacher should have knowledge of and experience using evidence based instructional interventions including but not limited to applied behavioral analysis principals, discrete trial teaching, functional visual communication systems, structured teaching approaches, and typical child development.
3. Licensed related service providers in areas to include (but not limited to): Speech Language Pathologist, Occupational Therapists and others as identified in the IEP/MP.
4. All paraprofessional staff must meet NCLB requirements:
  - a. Option 1 - 48 credits
    - Credits must be 100 level or higher in any subject area.
    - If earned after June 30, 2003, credits must include 3 credits in Math and 3 credits in English.
    - Must be earned from a regionally accredited institution.
    - Agencies must have all transcripts on file.
  - b. Option 2 - Associate's Degree
    - Degree must be earned with 100 level or higher courses.
    - For employees who earned a degree prior to January 8, 2002, the degree may include less than 100 level courses.
    - Must be earned from a regionally accredited institution.
    - Agencies must have all transcripts on file.
  - c. Option 3 – DOE compliance
    - Has met NCLB requirements under DOE guidelines and training.



## **INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES**

---

5. Adequate staff to student ratio, defined as not less than 1:6 teacher student ratio with individualized adult support as identified in student's IEP/MP is provided at all times to ensure safety for all activities and takes into consideration student characteristics. This is the total responsibility of the Special School program. DOE will not provide additional staff.
6. Staff is available to ensure student safety for early arriving or late departing students.
7. To ensure appropriate family involvement, the agency is responsible for locating and providing interpreters for families whose limited English proficiency or mode of communication would inhibit their ability to meaningfully participate in the student's education.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### K. COURT/DUE PROCESS HEARING TESTIMONY

<b>Service Description</b>	Participation in a court hearing or due process hearing at the request of DOE. This participation is in addition to a State representative's (i.e., Deputy Attorney General) presence in court and is intended to ensure that the court has access to all relevant information needed.
<b>Services Offered</b>	<p>Court/Due Process Hearing Testimony shall include <u>all</u> of the following:</p> <ol style="list-style-type: none"> <li>1. Attend court or due process hearings as requested by the DOE to present relevant educational data or information needed.</li> <li>2. Specific report writing by provider needed for court or due process hearing (Quarterly Progress Reports, Progress Notes, Clinical Evaluations, and other existing reports do not suffice). If a specific report must be submitted, the DOE may request that the contract provider complete specific documentation to assist in the writing of the report. The unit of service for the generation of the specific documentation is limited to a maximum of one hour.</li> <li>3. Recommendations are based on the presenting needs of the student. <b>Recommendations will not be accepted regarding specific services, methodology or persons</b> (i.e., student requires day treatment).</li> <li>4. Reports are made available to the DOE for review prior to the hearing.</li> </ol>
<b>Authorization</b>	<p>Prior authorization by the DOE via a completed procurement work order is required for each court hearing or due process hearing session or event. Participation is limited to 24 units. Specific rationale for exceeding the maximum units must be reviewed with school administrator or district educational specialist prior to the procurement of the service.</p> <p>Maximum Billable = 24 units (1 unit = 5 minutes, 12 units = 1 hour)</p>
<b>Referral Criteria</b>	<ol style="list-style-type: none"> <li>1. Student has an IEP or MP;</li> <li>2. Student has a scheduled court hearing or due process hearing; <b>AND</b></li> <li>3. The DOE identifies that participation by the contract provider would be helpful to the court or hearings officer in understanding the student's case.</li> </ol>
<b>Completion of Service</b>	This service delivery ends with the completion of the court hearing or due process hearing, or the acceptance of the requested documentation by the State representative.

#### Staffing Requirements:

1. Planning participants must meet the qualifications requirement for the particular level of care represented.

### **Service Operations:**

1. Present testimony at the court hearing or due process hearing.
2. The report, if requested, is signed by the appropriate professional.

### **Documentation**

Report as specified under Service Description, if necessary.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### L. EDUCATIONAL TEAM PLANNING AND PARTICIPATION

<b>Service Description</b>	Time for providers to meet with the student's educational team members, to develop, revise, and /or review an IEP/MP or other related educational plan such as an Functional Behavioral Assessment ( "FBA") or Behavioral Support Plan ("BSP"). Educational Team Planning and Participation consists of participation at non-regularly scheduled meetings.
<b>Services Offered</b>	<p>Educational Team Planning and Participation shall include <u>all</u> of the following:</p> <ol style="list-style-type: none"> <li>1. Attendance at a multi-disciplinary education planning conference and organized presentation of pertinent information educationally related to the goals and objectives of the student;</li> <li>2. Completion of an IEP/MP or BSP, as needed, identifying goals, measurable objectives and interventions based on student evaluation data;</li> <li>3. Documented verification of attendance such as a signing sign in sheet; and</li> <li>4. Documentation will occur for each meeting in the student's progress notes. The narrative should include the topic discussed and the outcome of the provider's participation.</li> </ol>
<b>Referral Criteria</b>	<ol style="list-style-type: none"> <li>1. The student has an IEP or MP;</li> </ol> <p style="text-align: center;"><b>AND</b></p> <ol style="list-style-type: none"> <li>2. The DOE identifies that participation of the contract provider in the education planning meeting would be educationally beneficial.</li> </ol>
<b>Authorization (Billable Hours):</b>	<p>If procured, prior authorization by the DOE via a completed procurement work order is required for each education planning meeting.</p> <p>DOE identifies that participation of the contract provider in the education planning meeting would be educationally beneficial. If another agency or entity requests the contract provider's presence at the meeting, DOE would not be the procurement agency for that service.</p> <p>Education planning meetings are limited to the actual time spent at the meeting. There is no reimbursement for travel time, wait time, or cancellations.</p> <p>Maximum Billable: Limited to actual time spent at the meeting. (1 unit = 5 minutes, 12 units = 1 hour)</p>
<b>Completion of Service</b>	<p>The service is complete when both of the following are complete:</p> <ol style="list-style-type: none"> <li>1. Participation at the education planning meeting is completed.</li> <li>2. Documented verification of attendance, such as the Service Verification Form, is completed.</li> </ol>

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

### **Staffing Requirements:**

Specific education planning participants must meet the qualifications requirement for the particular service or level of care provided.

### **Service Operations**

1. The contract provider ensures that adequate representation is available at the education planning meeting.
2. Participation in education planning is documented in student's IEP or MP.
3. Copy of the IEP and BSP are included in the student's record.

### **Documentation**

1. Contract and School-based providers are required to input information in the ISPED (or other designated database) modules such as IEP/MP, visit log, progress report and other modules that DOE requires within the timeframe required by the DOE.
2. Contract and school-based providers shall enter data into ISPED (or other designated database) on a weekly basis, within twenty-four (24) hours of service provision.
3. Data entry into ISPED (or other designated database) must be submitted before invoice submission and payment.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### M. SCHOOL CONSULTATION

<b>Service Description</b>	Consultation of a school-based or contract provider with regular and special education teachers, school administrators, and other school personnel regarding the behavior management of students as related to their IEP/MP goals and objectives. School consultation is delivered as requested by or agreed upon by the school.
<b>Services Offered</b>	<ol style="list-style-type: none"> <li>1. School consultation is a collaborative process, which serves to better link a student's BSP with his/her IEP/MP. School consultation facilitates communication between school personnel and behavioral health providers, between home and school, as well as between various school staff, such as between regular and special educators. While the focus of consultation is on behavioral management issues, it can include organizational management of the classroom (e.g., seating arrangements, scheduling) to boost the efficacy of inclusion of children with disabilities. The school-based or contract provider can provide general and intervention-specific information on particular behavioral disorders (e.g., Attention-Deficit/Hyperactivity Disorder, Tourette's Disorder) as well as certain social emotional variables (e.g., low self-esteem, poor achievement motivation, lack of social skills competence) and their potential impact on classroom performance.</li> <li>2. School consultation generally includes a face-to-face contact with teacher, administrator or other school personnel for the purpose of sharing information and facilitating communication. The contact may, however, be made by phone if the school visitation is not feasible and the goals of that consultation can be accomplished long-distance (e.g., helping a teacher fine-tune a behavior management plan).</li> <li>3. The following responsibilities of the school consultant are important to insure collaboration and efficacy: <ol style="list-style-type: none"> <li>a. Access and review pertinent educational and mental health data available in the student's clinical record.</li> <li>b. Adhere to school protocols regarding rules and responsibilities on school campus.</li> <li>c. Conduct classroom observation(s), if needed, to witness student's functioning in the school setting.</li> <li>d. Hold consultation meeting with appropriate school personnel to discuss specific issues/interventions related to student's school performance.</li> <li>e. Complete progress note and place in ISPED (or other designated database) within twenty-four (24) hours.</li> </ol> </li> </ol>
<b>Referral Criteria</b>	The DOE decides that delivery of school consultation would be educationally beneficial for the student and, if procured, the school approves the service.

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

<b>Authorizations</b>	<p>Prior authorization by the DOE via a completed procurement work order is required for each procured consultation event. School consultation is limited to 12 units per one episode. However, 24 units per episode will be allowed if a classroom observation is conducted per authorization.</p> <p>There is no reimbursement for travel time, wait time or no-shows for classroom observations.</p> <p>Maximum Billable: 24 units (1 unit = 5 minutes, 12 units = 1 hour)</p>
<b>Completion of Service</b>	<p>A progress note is completed and placed in ISPED (or other designated database), reflecting issues and behavior management strategies discussed, as well as school personnel's receptivity to the consultation intervention.</p>

### **Staffing Requirements:**

Specific education planning participants must meet the qualifications requirement for the particular level of care represented.

### **Service Operations:**

Progress notes are completed according to standards and placed in the student's records/ISPED (or other designated database) within twenty-four (24) hours.

### **Documentation**

1. School-based and contracted providers are required to input information in the ISPED (or other designated database) modules such as IEP/MP, visit log, progress report and other modules that DOE requires.
2. Providers shall enter data into ISPED (or other designated database) on a weekly basis within twenty-four (24) hours of service provision.
3. Data entry into ISPED (or other designated database) must be completed before invoice submission and payment.

***SECTION II – PART C:***

**EDUCATIONALLY SUPPORTIVE  
INTENSIVE MENTAL HEALTH SERVICES  
PERFORMANCE STANDARDS**



## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### A. ANCILLARY SERVICES

<b>Definition</b>	Ancillary services are services that are not available through existing contracted mental health services for youth. The funding for such services is limited and closely monitored to assure that disbursement is completed in the most clinically appropriate and fiscally responsible manner.
<b>Services Offered</b>	Supportive services that facilitate mental health treatment delivery as outlined in the CSP for time-limited interventions that are not available through existing contracted services. Examples include: transportation services, interpretive services, specific clinical services that are not available through contracted providers and special community programs or classes. The ancillary service must clearly support the youths improved functioning in their home/community and/or prevent the likelihood of movement to a higher level of care.
<b>Admission Criteria</b>	All of the following criteria must be met: <ol style="list-style-type: none"> <li>1. The identified youth meets at least one (1) of the Service Eligibility criteria for CAMHD (as described in General Standards, Section A, Access &amp; Availability);</li> <li>2. The youth is registered with a Branch and has an assigned MHCC; and</li> <li>3. The clinically appropriate requested services/items are required to allow the youth to meet the goals identified in the CSP and improve his/her functioning in the home/community or likely prevent the movement to a higher level of care. The services are procured by the MHCC after all other resources are exhausted.</li> </ol>
<b>Initial Authorizations</b>	The need for clinically appropriate services/items is identified by the CSP team and documented in the CSP, approved by the Branch Chief and procured by the MHCC. Unit = One (1) Dollar
<b>Re-Authorization</b>	The approval of the amounts greater than 5000 units requires the Division Chief's approval. Unit = One (1) Dollar
<b>Continuing Stay Criteria</b>	<u>All</u> of the following criteria are met as determined by treatment team review at least quarterly: <ol style="list-style-type: none"> <li>1. All admission criteria continue to be met;</li> <li>2. Services/items are being provided as indicated in the CSP and documented in progress notes and in plan reviews;</li> <li>3. There are regular and timely assessments and documentation of youth/family response to services. Timely and appropriate modifications are made to services and plans as needed;</li> <li>4. Goals, objectives, and discharge planning as related to ancillary funded services/items are reviewed by treatment teams at least quarterly;</li> <li>5. The youth/family continues to be actively involved in</li> </ol>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

	treatment interventions and treatment planning; and 6. The youth/family continues to be in need of ancillary funded services/items.
<b>Discharge Criteria</b>	Ancillary funded services/items are terminated when <u>one</u> (1) of the following criteria are met:  4. The youth is no longer eligible for CAMHD services. As part of discharge, the MHCC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible; 5. The youth is no longer eligible for services/items - (i.e., does not meet admission criteria); 6. The treatment team determines that services/items are no longer needed; and 7. Services/items are obtained through alternative sources.
<b>Service Exclusions</b>	1. Educational and basic health services are not to be provided through ancillary services. 2. Ancillary services are provided to augment and compliment other intensive mental health treatment services and cannot be a stand-alone service.

### **Staffing Requirements:**

1. If the ancillary service is a direct mental health service, then only a professional practitioner credentialed by CAMHD shall be allowed to perform this service.
2. All professionals providing direct services to youth and families shall have minimally met initial credentialing requirements for provisional appointments through submittal of required documents and satisfactory verbal verification of primary sources prior to date of hire.

### **INDIVIDUAL PRACTITIONER CREDENTIALING INFORMATION:**

#### **Qualified Mental Health Professional (QMHP):**

Must be a current Hawaii-licensed psychiatrist; board certified by the American Board of Psychiatry and Neurology (ABPN); and board certified or board eligible in Child and Adolescent Psychiatry. QMHP Psychiatrists in hospital-based settings must be ABPN board certified in Child and Adolescent Psychiatry.

**OR**

A Clinical or School Psychologist with a current Hawaii license/certification in Psychology.

**OR**

A certified Advanced Practice Registered Nurse (APRN) as a Psychiatric Clinical Nurse Specialist with a current Hawaii license/certification.

**OR**

A Hawaii licensed Clinical Social Worker (LCSW).

**OR**

A Hawaii licensed Marriage and Family Therapist (LMFT).

**OR**

## **INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES**

---

A Hawaii licensed Mental Health Counselor (LMHC) at such time inclusion is incorporated into the State Plan Amendment and Contractors are notified by CAMHD.

### **Clinical Operations**

If providing direct mental health services, then the professional is bound by all professional licensing requirements, professional ethics as well as CAMHD practice guidelines.

### **Documentation**

1. Provider must submit Ancillary Provider Registration Form to the MHCC prior to the initiation of services if providing mental health treatment service.
2. Original receipts for services/item must be provided as appropriate.
3. Providers of direct mental health services, please see Section I General Standards for additional documentation requirements:
  - E. Service Planning:
    - Mental Health Treatment Plan including transition, crisis and discharge planning;
    - Discharge Summary;
  - M. Maintenance of Service Records:
    - Progress Notes;
  - O. Minimum Reporting Requirements:
    - Monthly Treatment and Progress Summary.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### B. RESPITE SUPPORTS

<b>Definition</b>	Respite supports involve the provision of funds to families of eligible youth with serious emotional and/or behavioral challenges for the purpose of providing temporary short-term planned or emergency relief.
<b>Services Offered</b>	Respite is the provision of care, arranged by the parent(s) of an identified youth or youths to provide relief to the parent(s)/primary caregiver(s). Respite is integrated with other mental health services, as needed to promote coordinated, effective service delivery to the youth and family. Respite will be reviewed at least quarterly and adjusted as needed for a specific period of time.
<b>Admission Criteria</b>	<p><u>All</u> of the following criteria must be met:</p> <ol style="list-style-type: none"> <li>1. The identified youth meets at least one (1) of the service eligibility criteria for CAMHD (as described in General Standards, Section A, Access &amp; Availability);</li> <li>2. The youth is registered with a Branch and has an assigned MHCC;</li> <li>3. The clinically appropriate respite is deemed necessary to prevent out-of-home placement, prevent abuse/neglect, or preserve family unity and is related to specific goals and objectives and is documented in the CSP, as this is not an IEP service;</li> <li>4. The youth/family are actively involved in treatment implementation and treatment planning; and</li> <li>5. The need for respite services is identified by the CSP team and procured by the MHCC using the Quarterly Service Procurement Form.</li> </ol>
<b>Initial Authorizations</b>	<p>DOH Respite Authorization Form (Respite 1) is completed by the family and MHCC and submitted to CAMHD Fiscal Office. The DOH Respite Service Record (Respite 2) is completed by the parent and provider and submitted monthly to the CAMHD Branch.</p> <p>The family selects and negotiates payment with their respite provider(s). Respite provider rates are provided in accordance with the guidelines as written in the CAMHD Respite policy and procedure. Respite funds are not available to a non-custodial parent/caregiver.</p> <p>These services are time-limited with services reduced and then discontinued as family needs decrease.</p> <p>1 Unit = 1 Dollar</p>
<b>Continuing Stay Criteria</b>	<p><u>All</u> of the following criteria are met as determined by treatment team review at least quarterly:</p> <ol style="list-style-type: none"> <li>1. Services are being provided as indicated in the CSP and as documented on respite forms. This is documented in progress notes and in plan reviews; and</li> <li>2. The family continues to be in need of respite services and</li> </ol>

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

	there is a reasonable expectation that the youth will continue to make progress in reaching the goals identified within the CSP.
<b>Discharge Criteria</b>	Respite is terminated when <u>one</u> (1) of the following criteria are met: <ol style="list-style-type: none"><li>1. The youth is no longer eligible for CAMHD services. As part of discharge, the MHCC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible; or</li><li>2. The CSP team determines that services/items are no longer needed.</li></ol>
<b>Service Exclusions</b>	Respite services may not be used during school hours and is not an IEP service.

### Staffing Requirement

1. CAMHD is not involved in the credentialing of respite providers when the parent selects their own provider.
2. CAMHD does not train, monitor, or assume any liability for the services provided. Parents/families are responsible to arrange the delivery of respite services. Respite funds are not available to non-custodial parents/caregivers.

### Clinical Operations

1. CAMHD does not train, monitor, or assume any liability for the services provided.
2. Parents/families are responsible to arrange the delivery and payment of respite services.
3. CAMHD shall pay the parent or primary caregiver directly for services rendered.
4. CAMHD shall inform the parent or caregiver that:
  - a. If the parent or primary caregiver is reimbursed more than \$600 per year their reimbursement may be seen as a taxable income; and
  - b. If the parent or primary caregiver pays a private provider (someone who is not an employee of an agency) more than \$1000 in one (1) year, the family may be considered as an employer by the Internal Revenue Service and be liable for payroll taxes.

### Documentation

Documentation of Respite will be provided in accordance with the guidelines as written in the CAMHD Respite policy and procedures.

**C. PSYCHOSEXUAL ASSESSMENTS**

<b>Definition</b>	<p>Specialized diagnostic and evaluation services involving a strengths-based approach to identify youths' needs in the specific context of sexually abusive behaviors that have led to the youth being arrested, charged, or adjudicated for a sexual offense. Service components include conducting a comprehensive risk assessment and providing a written assessment report. Psychosexual assessments are preceded by information gathering from existing sources and should not occur unless a Comprehensive Mental Health assessment, Focused Mental Health assessment, Emotional Behavioral assessment, or Psychiatric Diagnostic Assessment has been completed within the last year. The psychosexual assessment is designed to build on the prior mental health assessment, using specialized psychometric instruments designed to assess sexual attitudes and interests.</p>
<b>Services Offered</b>	<ol style="list-style-type: none"> <li>1. Make appointment with the youth and family within one (1) week of referral and authorization;</li> <li>2. Review and incorporate any relevant data including developmental, psychosocial, medical, educational, clinical, behavioral, psychiatric and legal histories as provided by the MHCC or Juvenile Probation Officer;</li> <li>3. Conduct face-to-face or phone interviews with individuals who have first hand knowledge of the behavior, functioning and alleged offense of the youth. This must include obtaining the victim's statement about the offense and reports from the victim's mental health service provider whenever possible;</li> <li>4. Interview family/significant others and the youth face-to-face;</li> <li>5. Administer developmentally and clinically appropriate psychometric instruments that are evidence-based or are considered best practice among several offense treatment specialists to assess sexual attitudes and behaviors (e.g., Multiphasic Sex Inventory, Child Sexual Behavior Inventory, Adolescent Cognition Scale);</li> <li>6. Upon completion of the report, a feedback session must be conducted with the family/guardian; and</li> <li>7. Provide written report to the MHCC within twenty (20) working days from date of referral and authorization. If more time is need, the provider must contact the MHCC with his/her reason for time extension requested.</li> </ol>
<b>Admission Criteria</b>	<p><u>All</u> of the following criteria must be met:</p> <ol style="list-style-type: none"> <li>1. The identified youth meets at least one (1) of the service eligibility criteria for CAMHD (as described in General Standards, Section A, Access &amp; Availability);</li> <li>2. The youth is registered with a Branch and has an assigned MHCC;</li> </ol>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<ol style="list-style-type: none"> <li>3. The youth has been arrested, charged, or adjudicated for a sexual offense; and</li> <li>4. The CSP team has determined that the youth is in need of a specialized psychosexual evaluation because of a possible challenges in sexual behavior or attitudes that is an integral part of the youth's emotional or behavioral problems.</li> </ol>
<b>Initial Authorizations</b>	<p>Authorization may be up to twenty (20) units with approval of the Branch Chief.</p> <p>If there is no Mental Health Assessment current within one year, the Branch Chief may authorize the provider to complete a Comprehensive Mental Health Assessment along with the Psychosexual Assessment if the youth is SEBD eligible. If the youth is not SEBD eligible, then the IEP team must authorize an Emotional Behavioral Assessment prior to the Psychosexual.</p> <p>Unit = fifteen (15) minutes</p> <p>Procurement units reflect the time required for completing the review of data and assessment process. The units do include report-writing time, as it is incorporated in the unit cost. There is no payment for travel time, wait time, no shows, or cancellations.</p>
<b>Re-Authorization</b>	Not applicable.
<b>Discharge Criteria</b>	<p>At least <u>one</u> (1) of the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. The written report has been submitted to the MHCC and meets these standards for clinical and operational content. Assessments not meeting service content will be returned to the evaluator for amendment with suggested changes/concerns identified; or</li> <li>2. The youth/family no longer want to participate in this service and revokes consent in writing<sup>1</sup>.</li> </ol>
<b>Service Exclusions</b>	Youth in Community-based Residential Program Levels II and I.
<b>Clinical Exclusions</b>	<ol style="list-style-type: none"> <li>1. Youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior. Once stable, youth who otherwise meet the eligibility criteria may be referred.</li> <li>2. Youth eleven (11) years or younger.</li> </ol>

### Staffing Requirements:

1. The following practitioners may provide Psychosexual Assessment Services:
  - a. Credentialed QMHP with a minimum of three (3) year's experience conducting psychosexual assessments. Specifically, providers must have special training and demonstration of competency in specific testing measures for offenders and documentation of training in child abuse laws and procedures for evaluating and investigating psychosexual disorders.

<sup>1</sup> If the young adult or youth/family revokes consent or refuses to release the report to CAMHD, they will be liable for the cost of the service.

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

Providers must comply with any state certification or license requirements for performing specific assessments for offenders.

**OR**

- b. QMHP's who do not meet these requirements for relevant experience and demonstrated competency may perform Psychosexual Assessments under the direct supervision of another QMHP who is qualified under these standards. The supervising QMHP must co-sign the report acknowledging supervisory responsibility for the assessment.

### **Clinical Operations**

1. Direct service providers must coordinate with family/significant others and with other systems of care such as education, juvenile justice system, child welfare as needed to provide service complete the assessment.
2. Psychosexual Assessment report contains all service components as described in the documentation section.
3. Psychosexual Assessment report must be typed.
4. Psychosexual Assessment report is submitted to MHCC within twenty (20) working days of referral and authorization.

### **Documentation**

Complete written Psychosexual Assessment report is due within twenty (20) working days from date of referral and authorization. Written report includes all of the following:

1. Date(s) of assessment and date of report;
2. Identifying information: youth name, DOB, legal guardian, home school, grade level, IDEA status;
3. Reason for referral, including specific referral question(s);
4. Sources of information: including review of records, interviews, and assessment tools;
5. Brief developmental, sexual, medical, family, social, educational, substance use, psychiatric and trauma history highlighting information relevant to the referral question;
6. The youth's offense history, including information from the youth's Juvenile Justice records;
7. Description and history of presenting problems and concerns about behavior of a sexual nature;
8. Assessment results and interpretation; must include specific scores from psychometric instruments, plotted profiles when appropriate, and clear interpretations;
9. Description of youth and family strengths including formal and informal supports;
10. Clinical formulation and justification of diagnosis;
11. Diagnostic impressions: DSM IV-5 axes;
12. Summary of the finding including strengths, concerns and needs that must be met for the youth to function safely in their home and community. This section should summarize the risk assessment and include specific, detailed recommendations about the setting, intensity of intervention, and supervision necessary for effective treatment. The risk assessment should be based on all of the information collected (including interviews, records review, etc.) and should not rest solely on the results of risk assessment instruments. The summary should include an evaluation of whether the current or proposed school and community setting affords the level of structure and supervision necessary for the youth and the safety of others. Special consideration should be given to the needs and concerns of individuals who may have been victimized by the youth (e.g. siblings);
13. Strength-based recommendations with suggested goals and measurable objectives must be included. Recommendations will conform to the following:
  - a. Supported by research evidence or consensus of the evidence-based services committee;
  - b. Describe and address the needs of the youth and family and build on strengths;



## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

- c. Avoid specifying particular services, program or eligibility status. For example, it should not be specified that youth needs “residential treatment.” Instead, recommendations should focus on youth’s particular needs, e.g. “the youth is in need of close supervision in an highly structured environment due to ...”;
  - d. Include treatment interventions that are provided in the least restrictive manner that will address the needs of the youth and family. These may include therapeutic strategies or behavioral support approaches;
  - e. Report is signed by the assessor (and his/her supervisor when applicable) acknowledging responsibility for the assessment; and
14. Professionally recognized standards of ethical practices are followed in all assessments.

**D. INTENSIVE CASE MANAGEMENT**

<b>Definition</b>	<p>The primary function of CAMHD's MHCC is case management. Case management is a community-based, behavioral health treatment service that links and coordinates segments of the service-delivery system to ensure comprehensive therapeutic planning and intervention to meet an individual youth's and family's needs for improved community functioning. Case management includes comprehensive case assessment, case planning, connecting, brokering and ongoing monitoring of treatment services while advocating for youth and families to address their needs and overcome barriers to receiving quality services. These services are provided to increase community tenure, improve functioning, minimize psychiatric symptoms and develop an enhanced quality of life for youth and their families.</p> <p>Case management is delivered in a manner that is consistent with the CASSP principles of being child and family centered, culturally sensitive, community-based, and responsive to youth's right to be served in the least restrictive, most natural environment that is appropriate to individual needs.</p>
<b>Services Offered</b>	<ol style="list-style-type: none"> <li>1. The process of case management is accomplished largely through relationships. A therapeutic alliance between the MHCC and the youth and family is vital for maximizing the positive outcomes of case management and service provision interventions. Collaborative relationships with other professionals to accomplish coordinated assessment, evaluation, joint planning and decision-making, adherence to established Interagency Performance Standards and Practice Guidelines (IPSPG), and implementation of evidenced-based practices are essential. This requires the MHCC to: <ol style="list-style-type: none"> <li>a. Establish and maintain a supportive relationship with the youth/family. Serve as central point of contact for youth and/or family to the array of mental health services as well as to the entire system of care;</li> <li>b. Assist youth/family in problem solving and in developing necessary skills to remain in/return to the community;</li> <li>c. Conduct face-to-face and telephone contacts with the youth/family and collateral professionals for the purposes of mobilizing services and support, advocating on behalf of the youth/family, educating collaterals on needs of the youth/family, and coordinating services specified in the CSP and MHTP(s);</li> <li>d. Conduct at least monthly reviews of service delivery to ensure that quality service is being provided, i.e., interventions are addressing goals and goals are being met. Maintain ongoing contact with family to facilitate their needs being met, and their satisfaction with services;</li> <li>e. Conduct periodic observations as needed to address apparent lack of significant progress or lack of</li> </ol> </li> </ol>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p>integration of services for the youth; and</p> <p>f. Ensure that youth are receiving services in a timely manner i.e. within thirty (30) days of referral and authorization for services.</p> <ol style="list-style-type: none"> <li>2. Attendance at team meetings to facilitate evidence-based decision-making and actively participate in team-based decisions determining mental health services and formal and/or informal supports necessary in order for the youth to improve their level of functioning in home, school, and community settings.</li> <li>3. Ensure mental health services are occurring in a planned, timely and integrated manner as stated in the youth's CSP.</li> <li>4. Coordinate and monitor all treatment/services provided to the youth by all involved agencies/persons.</li> <li>5. Keep the Branch Chief, Clinical Director and/or Mental Health Supervisor informed regarding the ongoing status of the youth served.</li> <li>6. Participate in hearings; prepare clinical summaries/reports as necessary, (e.g., court reports; referral applications).</li> <li>7. Make appropriate collateral or other referrals as clinically indicated.</li> <li>8. Accompany the youth/family, as appropriate, for support and to address identified needs and/or treatment objectives.</li> <li>9. Maintain a clinical case record, documenting all services as required by the CAMHD policy and procedures. Submit reports to other agencies when requested and permitted by CAMHD policy.</li> <li>10. Ensure that appropriate Branch clinical staff review and approve all initial and continued stay services.</li> <li>11. Complete service authorization paperwork assuring that services are appropriate and clinically indicated to foster accomplishment of goals.</li> <li>12. Complete timely and efficient service authorization in order to prevent any interruption in service delivery or payment to providers.</li> </ol>
<b>Admission Criteria</b>	<p>All of the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. The identified youth meets at least one (1) of the service eligibility criteria for CAMHD (as described in General Standards, Section A, Access &amp; Availability); and</li> <li>2. The youth is registered with a Branch, and has an assigned MHCC.</li> </ol>
<b>Initial Authorizations</b>	Not applicable, provided by the MHCC
<b>Re-Authorization</b>	Not applicable
<b>Continuing Stay Criteria</b>	The identified youth continues to meet at least one of the service eligibility criteria for CAMHD (See General Standards, Section A)
<b>Discharge Criteria</b>	<p>At least <u>one</u> (1) of the following must be met:</p> <ol style="list-style-type: none"> <li>1. Youth is no longer eligible for CAMHD services. As part of discharge, the MHCC will help coordinate transfer to</li> </ol>

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

	appropriate treatment services in the least disruptive manner possible, or 2. Youth and family request discontinuation of this service and there is no indication of imminent harm to the youth if CAMHD involvement is stopped.
--	---

### Staffing Requirements:

1. Master's degree in social work or related human service or health care field, preferred. Bachelor's degree in a human services field and minimum of two (2) years of training or experience in child and adolescent mental health.
2. Knowledge of principles, methods, and techniques of human services work and concepts and theories of systems; inter-relationship of intellectual, emotional, physical, social and environmental factors influencing human behavior; normal human growth and development; psychiatric disorders; various treatment modalities; evidenced-based services; IPSPG; CASSP Principals; community resources and their effective utilization to help individuals and/or families.
3. Skills/abilities to collect, and evaluate data to make sound decisions; present ideas and information clearly and concisely orally and in writing; analyze situations and people accurately and develop an effective course of action; deal with people in a manner which will gain their confidence and cooperation; and maintain an objective and emotionally stable attitude in distressing situations; work effectively and harmoniously with others including professional and community groups; and exercise independent and mature judgments and decisions; understand and relate to persons from various cultural and economic backgrounds; maintain professional integrity.

### Clinical operations

CAMHD MHCC performs case management duties as assigned by the Branch Chief or designee with ongoing direction and supervision provided by the Mental Health Supervisor(s), Clinical Director and/or Branch Chief, or their designee.

### Documentation

1. The MHCC is responsible for maintaining the youth's chart in accordance with CAMHD chart audit standards.
2. The MHCC is responsible for facilitating and writing the CSP within thirty (30) days of eligibility determination. This plan is the overarching plan that documents that youth/family's needs and interventions/services provided by those involved in the youth and family's life. The CSP builds on individual strengths and pursues the youth/family's goals.
3. A transition/step-down component is contained within the CSP that informs all parties to the overall directions of treatment. The transition plan spells out the discharge criteria for any CAMHD service being procured and projected timeframe for that service. Additionally, the transition plan identifies any needed support or services that the youth/family will need to continue treatment in the least restrictive environment.
4. The crisis component of the CSP informs all parties as to the potential problem area(s), means of avoiding the problem, and how to intervene if the problem should occur including youth de-escalation preferences. The crisis component identifies any trigger or setting events known to the team.
5. Progress notes are written for each activity/event by the staff providing the service. The youth's full name and record number must be identified on each progress note page. Progress notes shall be entered in the youth's file within twenty-four (24) hours of the service. The focus in the content of notes clearly evidences the relationship of the intervention to the youth's

## **INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES**

---

CSP/IEP/MHTP plan. Additionally, progress notes need to address what may not be working and what will be done differently for better results. Progress notes also include collateral communications pertinent to the treatment of the youth.

6. The MHCC is responsible for making referrals for needed services on behalf of the youth/family. The MHCC must contact provider agencies, submit required documentation and get a copy of the Referral Acceptance Form for each service.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### E. INTENSIVE IN-HOME INTERVENTION

<b>Definition</b>	This service is designed to stabilize and preserve the family's capacity to improve the youth's functioning in the current living environment and to prevent the need for placement outside the home. This service is a time limited approach that incorporates evidenced-based interventions. The service utilizes family and youth centered interventions and adheres to the CASSP principles. This service may be delivered primarily to youth and their families in the family's home or community.
<b>Services Offered</b>	<ol style="list-style-type: none"> <li>1. Interventions which are based in family centered practices/techniques that: <ol style="list-style-type: none"> <li>a. Facilitate, support, or newly implement the appropriate evidence-based intervention at a level of intensity that requires home-based contact with the youth and family;</li> <li>b. Assist the family in setting up and maintaining consistent and strength-based interactions in the household;</li> <li>c. Define, or "reframe" problems and interventions so that all significant members have meaningful, strength-based roles;</li> <li>d. Resolve any crises, evaluate their nature, and intervene to reduce likelihood of further incidence;</li> <li>e. Utilize, ensure and facilitate access to formal and informal supports in the community and school;</li> <li>f. Increase capacity and strengths of the youth and family to support and facilitate gains achieved through evidence-based approaches (e.g., transitioning maintenance of behavior, support plan, to individuals within the youth's family or natural support network); and</li> <li>g. Services are directed towards the mental health needs of the identified youth in the context of developmentally appropriate, natural relationships.</li> </ol> </li> <li>2. Crisis management.</li> <li>3. Intensive family therapy.</li> <li>4. Linkages to other needed supports through internal, external coordination activities and referral.</li> <li>5. Evidence-based treatment interventions and when possible integrates them into family centered treatments.</li> <li>6. Self-help and living skills training for the youth.</li> <li>7. Services of a paraprofessional staff for skills training, as appropriate to the youth's needs.</li> <li>8. Parenting skills training to help the family build skills for coping with the youth's needs.</li> <li>9. Monitoring of progress and practices on a regular basis using reliable and valid measures and manages the presenting psychiatric symptoms.</li> <li>10. Working with parents in implementation of home-based behavioral support plans.</li> </ol>
<b>Admission Criteria</b>	<p><u>All</u> of the following criteria must be met:</p> <ol style="list-style-type: none"> <li>1. The identified youth meets at least one (1) of the service</li> </ol>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p>eligibility criteria for CAMHD (as described in General Standards, Section A, Access &amp; Availability);</p> <ol style="list-style-type: none"> <li>2. The youth is registered with a Branch, and has an assigned MHCC;</li> <li>3. The youth must be age three (3) through twenty (20) years;</li> <li>4. An adequate trial of active treatment in a less restrictive level has been unsuccessful or was given serious consideration but was found to be an inappropriate service;</li> <li>5. The CSP identifies this service and measurable objectives for outcomes of this service prior to admission; and</li> <li>6. The youth and/or family have insufficient or severely limited resources or skills to manage the behavioral/emotional problems of the youth without intensive supports in the home/community.</li> </ol>
<b>Initial Authorizations</b>	<p>Maximum of sixteen (16) units per day  Maximum of eighty (80) units per week  Maximum of four (4) weeks in duration  May be authorized by the MHCC</p> <p>Unit = fifteen (15) minutes</p>
<b>Re-Authorization</b>	<p>Re-authorizations may be as follows with approval by the MHS1.</p> <ul style="list-style-type: none"> <li>• Second month: <ul style="list-style-type: none"> <li>• Maximum of eight (8) units per day</li> <li>• Maximum of forty (40) units per week</li> </ul> </li> <li>• Third month: <ul style="list-style-type: none"> <li>• Maximum of four (4) units per day</li> <li>• Maximum of twenty (20) units per week</li> </ul> </li> <li>• Fourth month: <ul style="list-style-type: none"> <li>• Maximum of four (4) units per day</li> <li>• Maximum of twenty (20) units per week</li> </ul> </li> <li>• Fifth month: <ul style="list-style-type: none"> <li>• Maximum of four (4) units per day</li> <li>• Maximum of twenty (20) units per week</li> </ul> </li> </ul> <p>Any re-authorization request that exceed the five (5) months maximum or this titration must be approved by the Branch Clinical Psychologist.</p> <p>Unit = Fifteen (15) minutes</p>
<b>Continuing Stay Criteria</b>	<p><u>All</u> of the following criteria are met as determined by treatment team review:</p> <ol style="list-style-type: none"> <li>1. All admission criteria continue to be met;</li> <li>2. The measurable treatment goals have not been met and there are regular and timely assessments and documentation of youth/family response to services. Timely</li> </ol>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p>and appropriate modifications are made to services and plan as needed;</p> <ol style="list-style-type: none"> <li>3. There is a reasonable expectation that the youth and family will continue to make progress toward reaching the goals and objectives identified in the youth's MHTP and CSP within four (4) weeks;</li> <li>4. The youth's progress is not sufficient to allow movement to a less restrictive level of care as determined by the CSP team; and</li> <li>5. The youth continues to have specific needs that indicate that this is the most appropriate means of addressing those needs.</li> </ol>
<b>Discharge Criteria</b>	<p><u>One</u> (1) of the following must be met:</p> <ol style="list-style-type: none"> <li>1. The youth is no longer eligible for CAMHD services. As part of discharge, the MHCC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible;</li> <li>2. The youth/family no longer wants to participate in this service and revokes consent with no imminent danger to self or others;</li> <li>3. Targeted symptoms and/or maladaptive behaviors have abated to a level of severity, which no longer requires this level of care as documented by attainment of goals in the MHTP and CSP;</li> <li>4. Youth/family has demonstrated minimal or no progress toward treatment goals for a two (2) month period and appropriate modifications of MHTP has been made and implemented with no significant success and the CSP team determined that the youth is not benefiting from this service at this time; and</li> <li>5. Youth exhibits new symptoms and/or maladaptive behaviors, which cannot be safely and effectively, addressed through this service as determined by the CSP team.</li> </ol>
<b>Service Exclusions</b>	<ol style="list-style-type: none"> <li>1. Not offered at the same time as any out-of-home services except in cases where the youth has a planned discharge from out-of home care within thirty (30) days. Intensive In-home can begin to work with the youth and family for up to thirty (30) days to aid in family reunification following residential care.</li> <li>2. Not offered at the same time as any Intensive Outpatient or Multisystemic services.</li> </ol>
<b>Clinical Exclusions</b>	<p>Youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior. Once stable, youth who otherwise meet the eligibility criteria may be referred into the program.</p>



### Staffing Requirements:

In addition to the staffing requirements listed in the general standards, these staff requirements must also be followed. If the standards referenced here differ from those in the general standards, these staffing requirements will supersede the general standards.

1. Intensive In-Home Intervention is provided by:
  - a. A QMHP who has oversight and supervision responsibilities for all staff decisions made regarding youth/family treatment;
  - b. At least one (1) MHP experienced in evidence-based treatment and family based interventions and having at least three (3) years of experience working with youth with serious behavioral or emotional challenges. In many instances the MHP will be sufficient to deliver the appropriate services, however;
  - c. The MHP may partner with up to two (2) (not at the same time) paraprofessionals as needed, who work under the direct guidance of that MHP if the family situation requires the use of a paraprofessional. In such instances, the MHP will serve as the team leader, guiding, refining, and administering the intervention, with paraprofessional(s) providing additional supports for practice exercises, skills training, or other child or family interventions as directed by the MHP. The MHP is expected to have regular and frequent direct contact with the child and family (i.e. scheduled meetings at least every week and at least (twenty) 20% of the total face-to-face team contact time), particularly during the initial stages of intervention. As gains are consolidated, the frequency of contact by the MHP may decrease (but must remain at or above (twenty) 20%), signifying the need to transition to less intensive services. For purposes of coverage, the team may elect to include an additional MHP (not providing services at the same time).
2. The ratio shall not exceed twelve (12), families per primary MHP (team leader) at any time with the consideration that at least two (2) of the twelve (12) families will be stepping down to a less intensive level of care. This staff to family ratio takes into consideration evening and weekend hours, needs of special populations, and geographical areas to be covered.

### Clinical Operations

In addition to the clinical operation requirements listed in the general standards, these requirements must also be followed. If the standards referenced here differ from those in the general standards, these clinical operation requirements will supersede the general standards.

1. Services must be available twenty-four (24) hours a day, seven (7) days a week, through on-call arrangements with practitioners skilled in crisis and family based interventions. A team response is preferable when a family requires face-to-face crisis intervention.
2. These services include consultation and treatment with the youth and parent/caregiver(s) regarding medications, family based interventions, behavior management skills, dealing with treatment responses of the individual and other caregivers and family members, and coordinating with other treatment providers.
3. Program has an intake process that includes integration of information available on youth/family in the treatment planning to ensure appropriate and effective treatment. Program also has an established protocol for orienting youth to the program.
4. Team services are individually designed for each family, in full partnership with the family, to minimize intrusion and maximize strengths and independence. It is expected that problems will be defined, or "reframed," as much as possible so the interventions and goals will be strength-based and have significant meaning to all important members. Services are normally more intensive at the beginning of treatment and decrease over time as the individual and/or family's strengths and coping skills develop.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

5. Intensive In-Home Intervention must be provided through a cohesive team approach and services must be flexible with the capacity to address concrete therapeutic and environmental issues in order to stabilize the crisis situation as soon as possible. Services are evidence-based, family-centered, strengths based, culturally competent, active and rehabilitative, and delivered primarily in the individual's home or other locations in the community. Services are initiated when there is a reasonable likelihood that such services will lead to specific, observable improvements in the youth and family's functioning.
6. The majority of services [sixty percent (60%) or more] are provided face-to-face with youth and their families.
7. Service delivery must be preceded by a thorough assessment of the youth and their family so that an appropriate and effective treatment plan can be developed.
8. The Contractor must have the ability to deliver services in various environments, such as homes (birth, kin, adoptive and foster), schools, jails, homeless shelters, juvenile detention centers, street locations, etc.
9. The Contractor has policies, which govern the provision of services in natural settings and which document that it respects youths' and/or families' right to privacy and confidentiality when services are provided in these settings.
10. The Contractor has established procedures/protocols for handling emergency and crisis situations that describe methods for triaging youth who require psychiatric consultation or hospitalization.
11. Each Contractor has policies and procedures governing the provision of outreach services, including methods for protecting the safety of staff who engage in outreach activities.
12. A weekly summary and approval of supervised staff's note must be documented by the supervising QMHP.
13. The Contractor must have an Intensive In-Home Intervention organizational plan that addresses the following:
  - a. Description of the particular family centered interventions, coordination, crisis intervention and wraparound service models utilized, types of intervention practiced, and typical daily schedule for staff;
  - b. Description of the staffing pattern and how staff are deployed to ensure that the required staff-to-youth/family ratios are maintained, including how unplanned staff absences, illnesses, etc. are accommodated;
  - c. Description of the hours of operation, the staff assigned and types of services provided to youth/families;
  - d. Description as to how the plan for services is modified or adjusted to meet the needs specified in each youth's individual plan; and
  - e. A QMHP experienced in evidenced-based treatment who supervises treatment program and clinical responsibility.
14. The Contractor must do a Summary Annual Assessment for SEBD eligible youth in their care at the time the annual assessment is due on youth who have received at least three (3) months of services from the Contractor. See Summary Annual Assessment performance standards in Section II, Part D.
15. Please see Section I General Standards for additional clinical operation requirements:
  - D. CAMHD Co-Occurring Disorders;
  - F. Referral Process for Services:
    - Referral Acceptance;
  - G. CAMHD Continuity of Care;
  - H. Staffing;
  - I. Supervision;
  - J. Evaluation of Staff Performance;

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

- K. Credentialing Requirements;
- N. Service Quality;
- O. Minimum Reporting Requirements;
- P. Risk Management:
  - Criminal, Child Abuse, and Background Screening;
  - Safety;
  - Restraints and Seclusion;
  - Sentinel Events and Incidents;
  - Police.

### **Documentation**

In addition to the documentation requirements listed in the general standards, these requirements must also be followed. If the standards referenced here differ from those in the general standards, these documentation requirements will supersede the general standards.

1. Please see Section I, General Standards for additional documentation requirements:
  - E. Service Planning:
    - Mental Health Treatment Plan including transition, crisis and discharge planning;
    - Discharge Summary;
  - M Maintenance of Service Records:
    - Progress Notes;
  - O Minimum Reporting Requirements:
    - Monthly Treatment and Progress Summary.

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

### F. MULTISYSTEMIC THERAPY

<b>Definition</b>	Multisystemic Therapy (MST) is a time-limited, intensive family and community-based treatment that addresses the multiple determinants of serious anti-social behavior in juvenile offenders. MST addresses the factors associated with delinquency across youths' key settings, or systems (e.g., family, peers, school, neighborhood). Using the strengths of each system to foster positive change, MST promotes behavior change in the youths' natural environment.
<b>Services Offered</b>	<ol style="list-style-type: none"><li>1. Crisis management.</li><li>2. Linkages to other needed supports through internal and external coordination activities.</li><li>3. Evidence-based interventions.</li><li>4. Working with families in implementation of behavioral support plans.</li><li>5. Parenting skills training to help the family build skills for coping with the youth's behavior.</li></ol>
<b>Admission Criteria</b>	<p><u>All</u> of the following criteria must be met:</p> <ol style="list-style-type: none"><li>1. The identified youth meets at least one (1) of the service eligibility criteria for CAMHD (as described in General Standards, Section A, Access &amp; Availability);</li><li>2. The youth is registered with a Branch, and has an assigned MHCC;</li><li>3. The youth must be between the ages of eleven (11) and eighteen (18);</li><li>4. The youth displays willful misconduct behaviors (e.g., theft, property destruction, assault, truancy; as well as substance use/abuse or juvenile sex offense, when in conjunction with other delinquent behaviors);</li><li>5. The youth is at imminent risk of out-of-home placement or is currently in out-of-home placement and reunification is imminent within thirty (30) days of referral;</li><li>6. MST services are required to allow the youth to meet the goals identified in the CSP and improve his/her functioning in the home/community preventing movement to a higher level of care; and</li><li>7. The youth has an adult/parental figure that is willing to assume a long term parenting role (e.g., must be willing to participate with service providers for the duration of treatment).</li></ol>
<b>Initial Authorizations</b>	<p>Authorization may be up to ninety-six (96) units per day, one (1) month at a time for a maximum of five (5) months by the MHCC.</p> <p>Unit = fifteen (15) minutes</p>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

<b>Re-Authorization</b>	<p>Re-authorization may be up to ninety-six (96) units per day, one (1) month at a time for a maximum of four (4) monthly by the MHCC.</p> <p>Unit = fifteen (15) minutes</p> <p>Not to exceed five (5) months from date that consents to treatment are signed by caregiver unless approved by the CAMHD Medical Director via the MST System Supervisor.</p>
<b>Discharge Criteria</b>	<p><u>One</u> (1) of the following criteria must be met:</p> <ol style="list-style-type: none"> <li>1. The youth is no longer eligible for CAMHD services. As part of discharge, the MHCC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible;</li> <li>2. Youth exhibits new symptoms and/or maladaptive behaviors which cannot be safely and effectively addressed through this service;</li> <li>3. Youth has met at least seventy-five percent (75%) of the overarching treatment goals;</li> <li>4. The youth/family requests discharge and is not imminently dangerous to self/others;</li> <li>5. Youth has met fewer than seventy-five (75%) of the overarching goals and there is no evidence that continued services will result in youth's progress towards successful completion of those goals; and</li> <li>6. Youth's CSP team determines that out of home placement is more appropriate for youth and/or the MHCC is seeking such placement (in this case, MST services will be terminated within seven (7) days).</li> </ol>
<b>Service Exclusions</b>	<ol style="list-style-type: none"> <li>1. Not provided at the same time any out-of-home service, except in cases where the youth has a planned discharge from out-of-home service within thirty (30) days. MST can work with the youth and family for up to thirty (30) days prior to discharge when the transition plan calls for MST to aid in family reunification.</li> <li>2. Not provided at the same time as any Intensive In-Home Intervention or Intensive Outpatient services.</li> </ol>
<b>Clinical Exclusions</b>	<ol style="list-style-type: none"> <li>1. Youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior. Once stable, youth who otherwise meet the eligibility criteria may be referred to MST.</li> <li>2. Youth with an active thought disorder or severe mental illness.</li> <li>3. The youth with relatively mild behavioral problems that can effectively and safely be treated at a less intensive level of care.</li> <li>4. Youth living independently or for whom no primary caregiver can be identified.</li> <li>5. Juvenile Sex Offenders where the sex offense occurs in the absence of any other delinquent behavior.</li> </ol>

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

	6. Youth who have previously received MST services, regardless of outcome, unless specific conditions have been identified that have changed in the youth's ecology compared to the first course of MST, which would suggest that more favorable or generalizable outcomes could be obtained with a second course of MST. Such conditions are assessed by the MST supervisor with review by the System Supervisor.
--	--

### Staffing Requirements:

In addition to the staffing requirements listed in the general standards, these staff requirements must also be followed. If the standards referenced here differ from those in the general standards, these staffing requirements will supersede the general standards.

1. MST services are provided by a team of QMHP supervised clinicians, who must meet the requirements for MHP or Paraprofessional as specified in CAMHD credentialing requirements and IPSPG, with the exception that paraprofessionals must have a minimum of five (5) years of appropriate supervised experience. LSWs, MFT or APRNs are preferred. MST Clinical Supervisors must meet CAMHD requirements for QMHP, specified in IPSPG as well as the CAMHD requirements based upon NCQA standards. Licensed Ph.D.'s are preferred for the Clinical Supervisor position.
2. MST therapist to family ratio shall not exceed four to six (4-6) families per therapist at any given time with the consideration that one to two (1-2) families will be stepping down to a less intensive level of care. Staff to family ratio takes into consideration evening and weekend hours, needs of special populations, and geographical areas to be covered.
3. Staff must complete a five (5)-day training program designed by MST services prior to assignment of families/youth. In addition, staff must attend quarterly booster training sessions.
4. Staff shall receive at a minimum one (1) hour of group supervision and one (1) hour of MST services telephone consultation per week. Individual supervision occurs on an as needed basis.
5. MST therapists must be assigned on a full-time basis to MST services. MST supervisors must be assigned on at least a half-time basis to MST services, except where by provider contract they are committed as full-time (100% FTE) to MST services.

### Clinical Operations

In addition to the clinical operation requirements listed in the general standards, these requirements must also be followed. If the standards referenced here differ from those in the general standards, these clinical operation requirements will supersede the general standards.

1. Services must be available twenty-four (24) hours a day, seven (7) days a week.
2. These services include consultation with the youth, parents or other caregivers regarding behavior management skills, dealing with treatment responses of the individual and other caregivers and family members, and coordinating with other treatment providers.
3. Services are individually designed for each family, in full partnership with the family, to minimize intrusion and maximize independence. Services are normally more intensive at the beginning of treatment and decrease over time as the individual and/or family's strengths and coping skills develop.
4. MST services must be flexible with the capacity to address concrete therapeutic and environmental issues in order to stabilize a crisis situation as soon as possible. Services are evidence-based, family-focused, active and rehabilitative, and delivered primarily in the individual's home or other locations in the community. Services are initiated when there is a

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

reasonable likelihood that such services will lead to specific, observable improvements in the youth and family's functioning.

5. The majority of services, sixty percent (60%) or more, are provided face-to-face with the youth and their families and eighty percent (80%) of all face-to-face services are delivered in non-clinic settings over the authorization period. Service delivery must be preceded by a thorough assessment of the youth and their family so that an appropriate and effective treatment plan can be developed.
6. Services provided to youth must include coordination with family and significant others and with other systems of care such as education, juvenile justice, and youth welfare, when appropriate to treatment and educational needs.
7. Providers must have the ability to deliver services in various environments, such as homes (birth, kin, and adoptive/foster), schools, jails, homeless shelters, juvenile detention centers, street locations, etc.
8. The Contractor has policies, which govern the provision of services in natural settings and which document that it respects youths' and/or families' right to privacy and confidentiality when services are provided in these settings.
9. The Contractor has established procedures/protocols for handling emergency and crisis situations that describe methods for triaging youth who require psychiatric hospitalization.
10. Upon approval/acceptance of referral, the MST team will assign a therapist that must attempt to make face-to-face contact within twenty-four (24) hours (immediately if an emergency). If unable to make face-to-face contact within seventy-two (72) hours, the referring MHCC will be notified immediately regarding reasons for lack of contact. Each provider has policies and procedures governing the provision of outreach services, including methods for protecting the safety of staff who engage in outreach activities.
11. The Contractor must have a MST organizational plan that addresses the following:
  - a. Description of the particular family preservation, coordination, crisis intervention and wraparound services models utilized, types of intervention practiced, and typical daily schedule for staff;
  - b. Description of the staffing pattern and how staff are deployed to ensure that the required staff-to-youth ratios are maintained, including how unplanned staff absences, illnesses, etc. are accommodated;
  - c. Description of the hours of operation, the staff assigned and types of services provided to youth, families, parents, and/or guardians; and
  - d. Description as to how the plan for services is modified or adjusted to meet the needs specified in each youth's individual plan.
12. Please see Section I General Standards for additional clinical operation requirements:
  - D. CAMHD Co-Occurring Disorders;
  - G. CAMHD Continuity of Care;
  - H. Staffing;
  - I. Supervision;
  - J. Evaluation of Staff Performance;
  - K. Credentialing Requirements;
  - N. Service Quality;
  - O. Minimum Reporting Requirements;
  - P. Risk Management:
    - Criminal, Child Abuse, and Background Screening;
    - Safety;
    - Restraints and Seclusion;
    - Sentinel Events and Incidents;
    - Police.

### Documentation

1. MST therapist must complete MST Clinical Intake Assessment: list of reasons for referral, genogram, desired outcomes of key stakeholders, ecological strengths and challenges, “fit” assessment of referral behaviors.
2. The MST therapist must submit to the MHCC the Service Plan within five (5) days of intake. The MST Service Plan includes the MST Clinical Intake Assessment (see above), the MST Overarching Treatment Goals, the anticipated discharge date and the anticipated individualized transition/discharge criteria.
3. Therapists must complete “Case Consultation summary forms” weekly for case review during group supervision and MST case consultation sessions.
4. Please see Section I General Standards for additional documentation requirements:
  - E. Service Planning:
    - Discharge Summary;
  - M. Maintenance of Service Records:
    - Progress Notes;
  - O. Minimum Reporting Requirements:
    - Monthly Treatment and Progress Summary.



## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### G. RESPITE THERAPEUTIC FOSTER HOME

<b>Definition</b>	Mental health respite foster homes provide safe, short-term and supportive environments for youth with emotional and/or behavioral challenges. These foster homes provide structured relief to the parent(s)/caregiver(s) and families of these youth. This services provides support to the parent(s)/caregiver(s) in their efforts to continue caring for the youth in the home setting, thus reducing the risk of out of home placements at a higher level of care.
<b>Services Offered</b>	<ol style="list-style-type: none"> <li>1. Services are available twenty-four (24) hours/seven (7) days a week.</li> <li>2. Activities that support the development of age-appropriate daily living skills.</li> <li>3. Culturally relevant recreational and social activities that are rooted in evidence-based treatment and that support the development of interpersonal relationship and life skills through modeling and coaching.</li> <li>4. On-call crisis intervention and support to respite foster home parents on a twenty-four (24) hour basis.</li> <li>5. Medication monitoring.</li> </ol>
<b>Admission Criteria</b>	<p><u>All</u> of the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. The identified youth meets at least one (1) Service Eligibility criteria for CAMHD (as described in General Standards, Section A, Access &amp; Availability);</li> <li>2. The youth is registered with a Branch, and has an assigned MHCC;</li> <li>3. Respite Supports have been offered to the family and:               <ol style="list-style-type: none"> <li>a. Have been previously exhausted by the family; or</li> <li>b. Are unable to be used by the family at this time; and</li> </ol> </li> <li>4. Respite Foster Home Service is deemed necessary to support the goals and objectives in the CSP.</li> </ol>
<b>Initial Authorizations</b>	<p>Authorization may be up to a maximum of four (4) units per fiscal year by the MHCC.</p> <p>Units may be used in one (1) episode (e.g. one (1) four-day respite) or over several episodes of care (e.g. four (4) one-day respites) or combined in others way to best meet the needs of the youth and family.</p> <p>Unit = One (1) day</p>
<b>Re-Authorization</b>	Not applicable.
<b>Continuing Stay Criteria</b>	Not applicable.
<b>Discharge Criteria</b>	<p><u>One</u> (1) of the following criteria must be met:</p> <ol style="list-style-type: none"> <li>1. The youth no longer eligible for CAMHD services. As part of discharge, the MHCC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible;</li> <li>2. Family has been provided at least twenty-four (24) hours of respite;</li> </ol>

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

	<ol style="list-style-type: none"><li>3. A supportive living environment is established in the youth's home setting; and</li><li>4. Youth requires a higher level of care and is transferred out of Respite Home Service.</li></ol>
<b>Service Exclusions</b>	<ol style="list-style-type: none"><li>1. Not offered at the same time as any out-of-home services.</li><li>2. Respite Home is not a stand-alone service but is part of a larger treatment plan.</li></ol>
<b>Clinical Exclusions</b>	Youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior. Youth's clinical issues interfere with the safe provision of services in this level of care.

### Staffing Requirements:

In addition to the staffing requirements listed in the general standards, these staff requirements must also be followed. If the standards referenced here differ from those in the general standards, these staffing requirements will supersede the general standards.

1. Foster parents must be licensed with the Department of Human Services prior to service initiation.
2. Contractor must have a QMHP that oversees all program staff and is responsible for all clinical decisions made.
3. Youth who are unable to attend regularly scheduled day activities (e.g. school, work) must be provided supervision and therapeutic structure by program staff.
4. The program is required to have a psychiatrist or psychologist that provides twenty-four (24) hours on-call coverage, seven (7) days a week.
5. All respite foster parents must be trained in the provision of short-term care for youth with emotional and/or behavioral challenges, including training on medication administration.
6. Youth who need medication or nursing services have these services coordinated by the program so assistance is received in a timely manner.

### Clinical Operations

In addition to the clinical operation requirements listed in the general standards, these requirements must also be followed. If the standards referenced here differ from those in the general standards, these clinical operation requirements will supersede the general standards.

1. Services are available twenty-four (24) hours a day, seven (7) days a week.
2. The respite foster home will have no more than two (2) minor youth in the home and no more than two (2) foster youth in placement with them, unless a waiver is requested and approved by CAMHD for a sibling group placed together. There shall be a minimum of one (1) adult at home whenever the youth is present. The agency shall ensure additional staff support as necessary.
3. Foster families are required to receive at least two (2) hours a month of supervision from a Contractor's MHP. One (1) hour of the required supervision may be multi-family or group supervision.
4. In addition to all requirements for licensure of therapeutic foster families, Contractors will ensure that all therapeutic foster families receive at least twenty (20) hours of initial orientation to include: orientation to the Contractor agency; orientation to the Hawaii Child-Serving System and the role of Therapeutic Foster Care; understanding children and youth with emotional disturbances; providing positive behavioral support to children and adolescents; how to work as part of a treatment team; how to relate to the foster child's parents and family members; a review of State laws regarding child abuse and neglect reporting, reporting criminal behavior, and threats regarding suicide and homicide; and CPR and First Aid.

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

5. On an on-going basis, therapeutic foster families shall receive at least twenty (20) hours of training annually on topics related to mental health special needs youth. Documentation of all therapeutic foster family training is the responsibility of the Contractor.
6. At contract award, all Contractors of Therapeutic Foster Homes Services shall submit a list of foster families with all of the following information required on the Therapeutic Foster Home Profile Form (See Appendix B-15). Thereafter, biannually, and if necessary at the request of CAMHD, the Contractors shall update this report and submit any changes to the CAMHD Clinical Services Office, Utilization Management Section that shall maintain the information in accordance with all confidentiality requirements.
7. The Contractor shall have written policies and procedures and train staff on securing and storing medications; labeling and administering medications as ordered by a physician; recording medication administration, youth request for adjustment or change, and any side effects and notifying physician or advanced practice registered nurse immediately of possible side effects; and disposing of medications.
8. The program actively engages the youth in planned, structured, therapeutic activities, rooted in evidence-based treatment, throughout the day. There is a predictable and orderly routine that allows the youth to develop and enhance interpersonal skills and behaviors.
9. The respite foster home program has clear procedures, which specify its approach to positive evidence-based behavior management. These procedures must clearly delineate methods of training and implementation of positive evidence-based behavioral interventions.
10. The Contractor has established procedures/protocols in place for managing crises effectively and efficiently through the direct interventions of its professional clinical and medical staff. Included in these procedures are descriptions of methods for handling emergency and crisis situations and triaging youth who require more intensive interventions. Request for police assistance or crisis hotline assistance are limited to situations of imminent risk of harm to self or others.
11. MHP experienced in evidenced-based treatment has the clinical responsibility for the respite program.
12. Emergency contact information for the parent(s) or caregiver(s) is provided to the respite foster parent prior to or upon admission.
13. Please see Section I General Standards for additional clinical operation requirements:
  - D. CAMHD Co-Occurring Disorders;
  - F. Referral Process for Services:
    - Referral Acceptance;
  - G. CAMHD Continuity of Care;
  - H. Staffing;
  - I. Supervision;
  - J. Evaluation of Staff Performance;
  - K. Credentialing Requirements;
  - N. Service Quality;
  - O. Minimum Reporting Requirements;
  - P. Risk Management:
    - Criminal, Child Abuse, and Background Screening;
    - Safety;
    - Restraints and Seclusion;
    - Sentinel Events and Incidents;
    - Police.

### Documentation

In addition to the documentation requirements listed in the general standards, these requirements must also be followed. If the standards referenced here differ from those in the general standards, these documentation requirements will supersede the general standards.

1. Please see Section I General Standards for additional documentation requirements:
  - E. Service Planning:
    - Discharge Summary;
  - M. Maintenance of Service Records:
    - Progress Notes.
2. Therapeutic Foster Parents shall maintain progress notes that provide a) daily attendance log indicating the youth's presence or absence from the home including absences of twenty-four (24) hours or more and b) provide daily progress notes as documentation of treatment progress, events or activities youth engaged in and developmental milestones achieved. These notes shall be fully dated and signed by the foster parent, originals of which shall be placed in the agency's master youth file within seven (7) calendar days. These foster home progress notes may be in the form of a checklist or written note.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### H. RESPITE HOMES

<b>Definition</b>	Mental health respite homes provide safe, short-term and supportive environments for youth with emotional and/or behavioral challenges. These homes provide structured relief to the parent(s)/caregiver(s) and families of these youth. This services provides support to the parent(s)/caregiver(s) in their efforts to continue caring for the youth in the home setting, thus reducing the risk of out of home placements at a higher level of care.
<b>Services Offered</b>	<ol style="list-style-type: none"> <li>1. Services are available twenty-four (24) hours/seven (7) days a week.</li> <li>2. Activities that support the development of age-appropriate daily living skills.</li> <li>3. Culturally relevant recreational and social activities that are rooted in evidence-based treatment and that support the development of interpersonal relationship and life skills through modeling and coaching.</li> <li>4. On-call crisis intervention and support to respite home providers on a twenty-four (24) hour basis.</li> <li>5. Medication monitoring.</li> </ol>
<b>Admission Criteria</b>	<p><u>All</u> of the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. The identified youth meets at least one (1) Service Eligibility criteria for CAMHD (as described in General Standards, Section A, Access &amp; Availability).</li> <li>2. The youth is registered with a Branch, and has an assigned MHCC.</li> <li>3. Youth is between twelve (12) and eighteen (18) years of age.</li> <li>4. Respite Supports have been offered to the family and:               <ol style="list-style-type: none"> <li>a. Have been previously exhausted by the family; or</li> <li>b. Are unable to be used by the family at this time.</li> </ol> </li> <li>5. Respite Home Service is deemed necessary to support the goals and objectives in the CSP.</li> </ol>
<b>Initial Authorizations</b>	<p>Authorization may be up to a maximum of four (4) units per fiscal year by the MHCC.</p> <p>Units may be used in one (1) episode (e.g. one (1) four-day respite) or over several episodes of care (e.g. four (4) one-day respites) or combined in others way to best meet the needs of the youth and family.</p> <p>Unit = One (1) day</p>
<b>Re-Authorization</b>	Not applicable
<b>Continuing Stay Criteria</b>	Not applicable

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

<b>Discharge Criteria</b>	<p><u>One</u> (1) of the following criteria must be met:</p> <ol style="list-style-type: none"><li>1. The youth no longer eligible for CAMHD services. As part of discharge, the MHCC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible;</li><li>2. Family has been provided at least twenty-four (24) hours of respite;</li><li>3. A supportive living environment is established in the youth's home setting; and</li><li>4. Youth requires a higher level of care and is transferred out of Respite Home Service.</li></ol>
<b>Service Exclusions</b>	<ol style="list-style-type: none"><li>1. Not offered at the same time as any out-of-home services.</li><li>2. Respite Home is not a stand-alone service but is part of a larger treatment plan.</li></ol>
<b>Clinical Exclusions</b>	Youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior. Youth's clinical issues interfere with the safe provision of services in this level of care.

### Staffing Requirements:

In addition to the staffing requirement listed in the general standards, these staff requirements must also be followed. If the standards referenced here differ from those in the general standards, these staffing requirements will supersede the general standards.

1. At minimum, two (2) staff shall be on duty per shift in each living unit, with one (1) staff awake during overnight shifts.
2. A ratio of not less than one (1) staff to four (4) youth is maintained at all times, however there is a minimum requirement of two (2) staff on duty at all times.
3. At least one (1) staff member per shift is required to have a current CPR and First Aid certification.
4. Respite Home program staff must be supervised by a QMHP with experience in evidence-based treatments.
5. Youth who are unable to attend regularly scheduled day activities (e.g. school, work) must be provided supervision and therapeutic structure by program staff.
6. Staffing schedules shall reflect overlap in shift hours to accommodate information exchange for continuity of youth treatment, adequate numbers of staff reflective of the tone of the unit, appropriate staff gender mix, and the consistent presence and availability of a professional staff.
7. The program must adhere to all applicable facility licensing requirements/regulations.
8. The program is required to have a psychiatrist or psychologist that provides twenty-four (24) hours on-call coverage, seven (7) days a week.
9. Provider is to follow all applicable professional practice standards and ethical guidelines.
10. All respite home staff must be trained in the provision of short-term care for youth with emotional and/or behavioral challenges, including training on medication administration.
11. A licensed registered nurse is on staff or on contract to establish the system of operation for administering or supervising youth's medication and medical needs or requirements, monitoring the youth's response to medications, and training staff to administer medication and proper protocols.

### Clinical Operations

In addition to the clinical operation requirements listed in the general standards, these requirements must also be followed. If the standards referenced here differ from those in the general standards, these clinical operation requirements will supersede the general standards.

1. Services are available twenty-four (24) hours a day, seven (7) days a week.
2. The program will not exceed four (4) youth per residence.
3. The program actively engages the youth in planned, structured, therapeutic activities, rooted in evidence-based treatment, throughout the day. There is a predictable and orderly routine that allows the youth to develop and enhance interpersonal skills and behaviors.
4. The physical setting is home-like and furnished appropriate to the youths' developmental age.
5. The respite home program has clear procedures, which specify its approach to positive evidence-based behavior management. These procedures must clearly delineate methods of training and implementation of positive evidence-based behavioral interventions.
6. The Contractor has established procedures/protocols in place for managing crises effectively and efficiently through the direct interventions of its professional clinical and medical staff. Included in these procedures are descriptions of methods for handling emergency and crisis situations and triaging youth who require more intensive interventions. Request for police assistance or crisis hotline assistance are limited to situations of imminent risk of harm to self or others.
7. A QMHP experienced in evidenced-based treatment has the clinical responsibility for the respite program.
8. Emergency contact information for the parent(s) or caregiver(s) is provided to the respite home provider prior to or upon admission.
9. Please see Section I General Standards for additional clinical operation requirements:
  - F. CAMHD Referral Process for Services:
    - Referral Acceptance;
  - G. CAMHD Continuity of Care;
  - H. Staffing;
  - I. Supervision;
  - J. Evaluation of Staff Performance;
  - K. Credentialing Requirements;
  - N. Service Quality;
  - O. Minimum Reporting Requirements;
  - P. Risk Management:
    - Criminal, Child Abuse, and Background Screening;
    - Safety;
    - Restraints and Seclusion;
    - Sentinel Events and Incidents;
    - Police.

### Documentation

In addition to the documentation requirements listed in the general standards, these requirements must also be followed. If the standards referenced here differ from those in the general standards, these documentation requirements will supersede the general standards.

1. The respite home program shall maintain notes that provide a) a daily attendance log indicating the youth's presence or absence from the home including absences of twenty-four (24) hours or more b) daily progress notes as documentation of events or activities youth engaged in. These notes shall be fully dated and signed by staff, originals of which shall be maintained in the agency's master youth file within twenty-four (24) hours of service.

2. Please see Section I General Standards for additional documentation requirements:
  - E. Service Planning:
    - Discharge Summary;
  - M. Maintenance of Service Records:
    - Progress Notes.



## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### I. COMMUNITY MENTAL HEALTH SHELTER

<b>Definition</b>	Provide twenty-four (24) hour temporary short-term care for youth who are awaiting placement in an appropriate treatment facility. The youth usually remain involved in community-based educational, recreational, and occupational activities. These homes typically provide services for eight (8) youth per home. In this level of care, youth are supervised and provided services by professional and paraprofessional staff that have been recruited and trained to work with youth with emotional and behavioral challenges.
<b>Services Offered</b>	<ol style="list-style-type: none"><li>1. Services are available twenty-four (24) hours/seven (7) days a week.</li><li>2. Services are provided in a twenty-four (24) hour supervised residential setting.</li><li>3. Psycho-education and skill building activities that improve social interactions, self-esteem and self-management services.</li><li>4. On-call crisis intervention and support to shelter providers on a twenty-four (24) hour basis.</li><li>5. Activities that support the development of age-appropriate daily living skills.</li><li>6. Culturally relevant recreational and social group activities that are rooted in evidence-based treatment that supports the development of interpersonal relationship and life skills through modeling and coaching.</li><li>7. Individual Therapy at least one (1) time per week to address identified issues*.</li><li>8. Family Therapy at least two (2) times per month as indicated in youth's plan*.</li><li>9. Medication monitoring.</li><li>10. The program staff support youth with completing school assignments including evening and weekends and coordinates with the schools to ensure the youth continues their educational progress.</li></ol>
<b>Admission Criteria</b>	<p><u>All</u> of the following criteria are met:</p> <ol style="list-style-type: none"><li>1. The identified youth meets at least one (1) of the Service Eligibility criteria for CAMHD (as described in General Standards, Section A, Access &amp; Availability);</li><li>2. The youth is registered with a Branch, and has an assigned MHCC;</li><li>3. The youth must be between the ages of twelve (12) to eighteen (18) years of age;</li><li>4. Youth is on an appropriate treatment facility active waitlist; and</li><li>5. Youth will transition out of the shelter within one (1) month.</li></ol>
<b>Initial Authorizations</b>	Authorization may be up to fifteen (15) units the by MHCC.

\* See performance standard for service referenced.

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

	Unit = One (1) day.
<b>Re-Authorization</b>	Reauthorize may be up to fifteen (15) units with approval from MHS1. Unit = One (1) day
<b>Continuing Stay Criteria</b>	<u>All</u> of the following criteria are met as determined by treatment team review: <ol style="list-style-type: none"><li>1. Youth is still on active waitlist awaiting opening in an appropriate treatment facility; and</li><li>2. Youth is expected to transition out of shelter within the next two weeks.</li></ol>
<b>Discharge Criteria</b>	<u>One</u> (1) of the following criteria must be met: <ol style="list-style-type: none"><li>1. The youth is no longer eligible for CAMHD services. As part of discharge, the MHCC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible;</li><li>2. The youth/family no longer wants to participate in this service and revokes consent with no imminent danger to self or others; or</li><li>3. Youth has transitioned to an appropriate treatment facility.</li></ol>
<b>Service Exclusions</b>	Not offered at the same time as any out-of-home services or Intensive Home, Community-based services or Intensive Outpatient service.
<b>Clinical Exclusions</b>	Youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior.

### Staffing Requirements:

In addition to the staffing requirements listed in the general standards, these staff requirements must also be followed. If the standards referenced here differ from those in the general standards, these staffing requirements will supersede the general standards.

1. At minimum, two (2) staff shall be on duty per shift in each living unit, with one (1) staff awake during overnight shifts.
2. A ratio of not less than one (1) staff to four (4) youth is maintained at all times, however there is a minimum requirement of two (2) staff on duty at all times.
3. At least one (1) staff member per shift is required to have a current CPR and First Aid certification.
4. All staff are trained in the provision of psycho-educational and counseling service for youth with emotional and/or behavioral challenges.
5. A licensed registered nurse is on staff or on contract to establish the system of operation for administering or supervising youth's medication and medical needs or requirements, monitoring the youth's response to medications, and training staff to administer medication and proper protocols.
6. Therapeutic living programs must be supervised by a QMHP with experience in evidence-based treatments. Staff includes: paraprofessionals, MHPs and QMHPs.

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

7. Youth who are unable to attend regularly scheduled day activities (e.g. school, work) must be provided supervision and therapeutic structure by program staff.
8. Staffing schedules shall reflect overlap in shift hours to accommodate information exchange for continuity of youth treatment, adequate numbers of staff reflective of the tone of the unit, appropriate staff gender mix, and the consistent presence and availability of a professional staff.
9. The program must adhere to all applicable facility licensing requirements/regulations.
10. The program must have a psychiatrist or psychologist that provides twenty-four (24) hour on-call coverage, seven (7) days a week, through a contractual relationship or on staff.
11. Provider is to follow all applicable professional practice standards and ethical guidelines.

### Clinical Operations

In addition to the clinical operation requirements listed in the general standards, these requirements must also be followed. If the standards referenced here differ from those in the general standards, these clinical operation requirements will supersede the general standards.

1. Services are available twenty-four (24) hours a day, seven (7) days a week.
2. The program will not exceed eight (8) youth per residence.
3. The agency has on-call crisis intervention and support available to the shelter program on a twenty-four (24) hour basis.
4. The program actively engages the youth in planned, structured, therapeutic activities, rooted in evidence-based treatment, throughout the day, seven (7) days a week. There is a predictable and orderly routine that allows the youth to develop and enhance interpersonal skills and behaviors.
5. The physical setting is home-like and furnished appropriate to the youths' developmental age. The youth are encouraged to appropriately decorate and maintain their personal space.
6. Contractor must provide schools with emergency contact information for staff response in cases of illness or incident within the school setting, for those youth attending community schools.
7. The program has clear procedures, which specify its approach to positive evidence-based behavior management. These procedures must clearly delineate methods of training and implementation of positive evidence-based behavioral interventions.
8. The agency has established procedures/protocols in place for managing crises effectively and efficiently through the direct interventions of its professional clinical and medical staff. Included in these procedures are descriptions of methods for handling emergency and crisis situations and triaging youth who require more intensive interventions. Request for police assistance or crisis hotline assistance are limited to situations of imminent risk of harm to self or others.
9. Please see Section I General Standards for additional clinical operation requirements:
  - D. CAMHD Co-Occurring Disorders;
  - F. Referral Process for Services:
    - Referral Acceptance;
  - G. CAMHD Continuity of Care;
  - H. Staffing;
  - I. Supervision;
  - J. Evaluation of Staff Performance;
  - K. Credentialing Requirements;
  - N. Service Quality;
  - O. Minimum Reporting Requirements;
  - P. Risk Management:
    - Criminal, Child Abuse, and Background Screening;
    - Safety;
    - Restraints and Seclusion;
    - Sentinel Events and Incidents;

- Police.

### **Documentation**

In addition to the documentation requirements listed in the general standards, these requirements must also be followed. If the standards referenced here differ from those in the general standards, these documentation requirements will supersede the general standards.

1. Please see Section I General Standards for additional documentation requirements:
  - E. Service Planning:
    - Mental Health Treatment Plan including transition, crisis and discharge planning;
    - Discharge Summary;
  - M. Maintenance of Service Records:
    - Progress Notes;
  - O. Minimum Reporting Requirements:
    - Monthly Treatment and Progress Summary.

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

### J. THERAPEUTIC FOSTER HOME

<b>Definition</b>	This service is an intensive community-based treatment service provided in a home setting for youth with emotional challenges. Specialized therapeutic foster care incorporates evidence-based psychosocial treatment services. These homes provide a normative, community-based environment through therapeutic parental supervision, guidance, and support for youth capable of demonstrating growth in such a setting. These youth are generally capable of attending their home school or an alternative community educational or vocational program. Such homes may also be beneficial for youth in transition from a more restrictive placement as these homes offer a family-like orientation. Foster homes with therapeutic services are appropriate for youth in need of relatively long-term treatment placements of six (6) to nine (9) months and/or shorter-term crisis stabilization.
<b>Services Offered</b>	<ol style="list-style-type: none"><li>1. Intake evaluation and informal assessment of each youth for appropriateness for program.</li><li>2. Evidence-based treatment training, including positive behavioral support training, for the therapeutic foster care parents as well as for the family of origin.</li><li>3. Treatment team participates in regular face-to-face meetings [no less than two (2) one-hour meetings per month] with the specialized therapeutic foster parents in order to monitor the youth's progress and to discuss treatment strategies and services.</li><li>4. Skills development activities for the youth.</li><li>5. Supportive counseling for the youth.</li><li>6. Coordination with school personnel to implement and provide academic support in the foster home setting for the youth.</li><li>7. Weekly evidence-based Family Therapy services are provided to the family of origin of each youth in placement as indicated on the youth's plan*. The therapist's role is to support the family with an emphasis on family-based implementation of individualized behavioral approaches developed in the TFH setting. The program meets weekly with the parents of origin, from the first week the youth begins foster care placement until the youth transitions out of foster care placement, to provide parent education, information and skill building as necessary for them to implement the evidence-based interventions in the home of origin that have been found to be effective for the youth.*</li><li>8. Where custody has been permanently removed from the family of origin, or where long-term foster custody has been arranged with an identified DHS foster family and the youth will not be returned to the home setting, a DHS identified adult/parental figure able to assume long-term parenting</li></ol>

---

\* See performance standard for service referenced.

\* See performance stand for service referenced.

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p>responsibilities will participate in the weekly family therapy sessions.</p> <p>9. Active, on-going treatment for the youth is based on the measurable goals and objectives that are part of the CSP and MHTP. The treatment is focused on returning the youth home. Where DHS holds permanent custody or where long-term foster custody has been arranged with an identified DHS family, these goals are integrated with the permanency plans and/or support successful transition of the youth to ongoing DHS foster care or to an independent living program.</p> <p>10. Weekly evidence-based Individual Therapy is provided to each youth to address identified issues*. The therapist's role is to support the youth's adjustment in the foster home where the main treatment effect is to occur. The therapist's job is to provide support for the youth and to help him/her acquire and practice the skills needed to relate successfully to adults and peers.</p>
<b>Admission Criteria</b>	<p><u>All</u> of the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. The identified youth meets at least one (1) of the Service Eligibility criteria for CAMHD (as described in General Standards, Section A, Access &amp; Availability);</li> <li>2. The youth is registered with a Branch, and has an assigned MHCC;</li> <li>3. The youth must be between the ages of three (3) and seventeen (17);</li> <li>4. The youth has identified challenging behavioral or emotional mental health issues that requires temporary out-of-home placement;</li> <li>5. There must be a reasonable expectation that the youth and the family can benefit from therapeutic foster care within six (6) to nine (9) months;</li> <li>6. The measurable treatment goals are identified in the youth's CSP prior to admission;</li> <li>7. An adequate trial of active treatment at a less restrictive level had been unsuccessful or given serious consideration and found to be inappropriate;</li> <li>8. The CSP identifies this services and measurable objectives for outcomes of this service prior to admission; and</li> <li>9. Youth's documented needs can best be met in a structured and consistent family-like environment.</li> </ol>
<b>Initial Authorizations</b>	<p>Authorization may be up to thirty-one (31) units per month for three (3) months by the MHCC.</p> <p>Unit = One (1) day.</p>
<b>Re-Authorization</b>	<p>Reauthorize may be up to thirty-one (31) units per month for six (6) months with approval by the MHS1.</p>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p>Unit = One (1) day.</p> <p>Any request for re-authorization beyond nine (9) months must be approved by the Clinical Psychologist.</p>
<b>Continuing Stay Criteria</b>	<p><u>All</u> of the following criteria are met as determined by treatment team review:</p> <ol style="list-style-type: none"> <li>1. All admission criteria continue to be met;</li> <li>2. Services/items are being provided as indicated in the CSP and MHTP and there are regular and timely assessments and documentation of youth/family response to services. Timely and appropriate modifications are made to services and plan as needed;</li> <li>3. The youth continues to have challenging behavioral or emotional mental health issues and therapeutic foster care is the most appropriate means of meeting those needs; and</li> <li>4. There is a reasonable expectation that within an additional four (4) weeks the youth will continue to make significant progress toward reaching the treatment goals identified in the MHTP and CSP.</li> </ol>
<b>Discharge Criteria</b>	<p><u>One</u> (1) of the following criteria must be met:</p> <ol style="list-style-type: none"> <li>1. The youth is no longer eligible for CAMHD services. As part of discharge, the MHCC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible;</li> <li>2. The youth/family no longer wants to participate in this service and revokes consent with no imminent danger to self or others;</li> <li>3. Targeted symptoms and/or behaviors have abated to a level of severity which no longer requires this level of care as documented by attainment of goals in the MHTP and CSP;</li> <li>4. Youth has demonstrated minimal or no progress toward treatment goals for a two (2) month period and appropriate modifications of the MHTP have been made and implemented with no significant success and the CSP team determines that the youth is not benefiting from this services at this time;</li> <li>5. Youth exhibits new symptoms and/or maladaptive behaviors which cannot be safely and effectively address through this service;</li> <li>6. The youth has made progress on goals and objectives outlined in the CSP/MHTP such that he or she is able to transition back to his/her family; and</li> <li>7. The youth has the knowledge and supports necessary to sustain treatment outcomes and to support a successful transition to a permanent placement or independent living program.</li> </ol>
<b>Service Exclusions</b>	<ol style="list-style-type: none"> <li>1. Not offered at the same time as any out-of-home service.</li> <li>2. Not offered at the same time as any Intensive In-Home</li> </ol>

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

	Intervention, Multisystemic Therapy, Functional Family Therapy or intensive outpatient services except where the youth will be transitioned out of the TFH and into the identified service within thirty (30) days referral.
<b>Clinical Exclusions</b>	Youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior. Once stable, youth who otherwise meet the eligibility criteria may be referred into a therapeutic foster home.

### Staffing Requirements:

In addition to the staffing requirements listed in the general standards, these staff requirements must also be followed. If the standards referenced here differ from those in the general standards, these staffing requirements will supersede the general standards.

1. Foster parents must be licensed with the Department of Human Services prior to service initiation.
2. Foster families are required to receive at least two (2) hours a month of supervision from a Contractor's MHP. One (1) hour of the required supervision may be multi-family or group supervision.
3. Contractor must have a QMHP that oversees all program staff and is responsible for all clinical decisions made.

### Clinical Operations

1. In addition to the clinical operation requirements listed in the general standards, these requirements must also be followed. If the standards referenced here differ from those in the general standards, these clinical operation requirements will supersede the general standards.
2. Services are available twenty-four (24) hours a day, seven (7) days a week.
3. The program provides foster parents with a written plan for providing emergency and psychiatric care prior to placement.
4. In addition to all requirements for licensure of therapeutic foster families, Contractors will ensure that all therapeutic foster families receive at least twenty (20) hours of initial orientation to include: orientation to the Contractor agency; orientation to the Hawaii Child-Serving System and the role of Therapeutic Foster Care; understanding children and youth with emotional disturbances; providing positive behavioral support to children and adolescents; how to work as part of a treatment team; how to relate to the foster child's parents and family members; a review of State laws regarding child abuse and neglect reporting, reporting criminal behavior, and threats regarding suicide and homicide; how to access Contractor's respite homes and CPR and First Aid.
5. On an on-going basis, therapeutic foster families shall receive at least twenty (20) hours of training annually on topics related to mental health special needs youth. Documentation of all therapeutic foster family training is the responsibility of the Contractor.
6. The foster home will have no more than two (2) minor youth in the home and no more than two (2) foster youth in placement with them, unless a waiver is requested and approved by CAMHD for a sibling group placed together. There shall be a minimum of one (1) adult at home whenever the youth is present. The agency shall ensure additional staff support as necessary.
7. A QMHP or QMHP-supervised MHP provides weekly evidence-based family therapy services to the family of origin of each youth in placement as well as weekly evidenced-based treatment to each youth in the program.



## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

8. At contract award, all Contractors of Therapeutic Foster Homes Services shall submit a list of foster families with all of the following information required on the Therapeutic Foster Home Profile Form (See Appendix B-15). Thereafter, biannually, and if necessary upon CAMHD's request, the Contractors shall update this report and submit any changes to the CAMHD Clinical Services Office, Utilization Management Section that shall maintain the information in accordance with all confidentiality requirements.
9. The Contractor shall have written policies and procedures and train staff on securing and storing medications; labeling and administering medications as ordered by a physician; recording medication administration, youth request for adjustment or change, and any side effects and notifying physician or advanced practice registered nurse immediately of possible side effects; and disposing of medications.
10. The Contractor must have policies that ensure that foster parents plan for the foster youth's regular medical and dental services, and keep the provider agency informed of any health problems or any changes that adversely affect the youth in foster care.
11. Program has an intake process that includes integration of information available on youth/family in the treatment planning to ensure appropriate and effective treatment. Program also has an established protocol for orienting youth to the program.
12. The Contractor must have clear procedures, which specify its approach to positive evidence-based behavior management and to evidence-based family therapy interventions. These procedures must clearly delineate methods to be used for the training and implementation of these evidence-based behavioral interventions.
13. The Contractor has established procedures/protocols in place for managing crises effectively and efficiently through the direct interventions of its professional staff. Included in these procedures are descriptions of methods for handling emergency and crisis situations and triaging youth who require more intensive interventions. Request for police assistance or crisis hotline assistance are limited to situations of imminent risk of harm to self or others.
14. The Contractor must do a Summary Annual Assessment for SEBD eligible youth in their care at the time the annual assessment is due on youth who have received at least three (3) months of services from the Contractor. See Summary Annual Assessment performance standards in Section II, Part D.
15. Eight (8) therapeutic passes are allowed per episode of care for each youth in the program to assist him/her in meeting the MHTP goals as defined in the general standards.
16. Up to seven (7) bed hold days may be used to reserve the bed for a youth who is absent from the program as defined in the general standards.
17. Please see Section I General Standards for additional clinical operation requirements:
  - D. CAMHD Co-Occurring Disorders;
  - F. Referral Process for Services:
    - Referral Acceptance;
  - G. CAMHD Continuity of Care;
  - H. Staffing;
  - I. Supervision;
  - J. Evaluation of Staff Performance;
  - K. Credentialing Requirements;
  - N. Service Quality;
  - O. Minimum Reporting Requirements;
  - P. Risk Management:
    - Criminal, Child Abuse, and Background Screening;
    - Safety;
    - Restraints and Seclusion;
    - Sentinel Events and Incidents;

- Police;
- V. Bed Hold and Therapeutic Passes:
  - Bed Hold;
  - Therapeutic Pass.

### Documentation

In addition to the documentation requirements listed in the general standards, these requirements must also be followed. If the standards referenced here differ from those in the general standards, these documentation requirements will supersede the general standards.

1. Please see Section I General Standards for additional documentation requirements:
  - E. Service Planning:
    - Mental Health Treatment Plan including transition, crisis and discharge planning
    - Discharge Summary;
  - M. Maintenance of Service Records;
  - O. Minimum Reporting Requirements:
    - Monthly Treatment and Progress Summary;
2. Therapeutic Foster Parents shall maintain progress notes that provide a) daily attendance log indicating the youth's presence or absence from the home including absences of twenty-four (24) hours or more and b) provide daily progress notes as documentation of treatment progress, events or activities youth engaged in and developmental milestones achieved. These notes shall be fully dated and signed by the foster parent, originals of which shall be placed in the agency's master youth file within seven (7) calendar days. These foster home progress notes may be in the form of a checklist or written note.

**K. MULTIDIMENSIONAL TREATMENT FOSTER CARE**

<b>Definition</b>	<p>Multidimensional Treatment Foster Care (MTFC) services are intensive family-based services provided in a foster family setting to youth with a history of delinquent and/or disruptive behaviors and emotional challenges.</p> <p>The two (2) major aims of MTFC are:</p> <ol style="list-style-type: none"> <li>1. To create opportunities so that youth are successfully able to live in foster families rather than in group or institutional settings, and</li> <li>2. To simultaneously prepare parents, relatives, or other aftercare resources to provide these same youth with effective parenting so that positive changes made in the MTFC setting can be sustained over the long run.</li> </ol> <p>MTFC is an evidence-based treatment intervention which utilizes trained and supervised foster parents to:</p> <ol style="list-style-type: none"> <li>1. Provide youth in care with close supervision;</li> <li>2. Provide youth with fair and consistent limits and consequences;</li> <li>3. Provide a supportive relationship with the youth; and</li> <li>4. Minimize association with peers who may be a bad influence.</li> </ol> <p>Youth in MTFC are generally capable of attending their home school or an alternative community-based educational/vocational program. Placements generally range from six (6) to nine (9) months. This level of care is primarily intended as an alternative to Therapeutic Group Home or Community-based Residential service.</p>
<b>Services Offered</b>	<ol style="list-style-type: none"> <li>1. The program has an intake process that includes introducing the youth and family to the program, review and assessment of existing documentation to integrate into the treatment plan within their milieu.</li> <li>2. Maintain collateral contacts with the MHCC.</li> <li>3. Crisis management 24 hours/day, 7 days/week as needed.</li> <li>4. MTFC Foster Parents provide closely supervised behavioral interventions via an individualized level and point system and contingent positive and negative consequences.</li> <li>5. The MTFC Clinical Supervisor participates in weekly face-to-face meetings with all foster parents and with all Clinical Team members in order to monitor each youth's progress, discuss treatment strategies, and effectively track outcomes.</li> <li>6. The MTFC Parent Daily Report (PDR) Caller maintains daily contact with all foster parents in order to monitor progress via the collection of behaviorally based data.</li> <li>7. MTFC Foster Parents coordinate with school personnel via a Daily School Card in order to strengthen effective academic support in the home setting.</li> <li>8. An MTFC Peer Counselor provides individualized pro-social</li> </ol>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p>activities coaching for each youth weekly.</p> <ol style="list-style-type: none"> <li>9. The MTFC Individual Therapist provides weekly sessions with each youth in support of individualized behavioral approaches developed over time in the MTFC setting.</li> <li>10. The MTFC Family Therapist provides weekly evidence-based therapy to the youth's family of origin with an emphasis on family-based implementation of individualized behavioral approaches developed in the MTFC setting.</li> <li>11. Active, on-going treatment is based on measurable goals and objectives that are part of the youth's CSP and MHTP. Treatment is focused on returning the youth home or, for youth in DHS custody, on successful transition to a kinship placement, long-term foster family, or independent living program.</li> </ol>
<b>Admission Criteria</b>	<p><u>All</u> of the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. The identified youth meets at least one (1) of the Service Eligibility criteria for CAMHD (as described in General Standards, Section A, Access &amp; Availability);</li> <li>2. The youth is registered with a Branch, and has an assigned MHCC;</li> <li>3. The youth must be between the ages of eleven (11) and seventeen (17);</li> <li>4. The youth must be identified as needing an out-of-home service due to severe and persistent problem behavior. The CSP identifies this service and measurable objectives for outcomes of this service prior to admission;</li> <li>5. There must be reasonable expectation that the youth and family can benefit from MTFC within six (6) to nine (9) months;</li> <li>6. An adequate trial of active treatment at a less restrictive level had been unsuccessful or given serious consideration and found to be inappropriate. This level of care is primarily intended as an alternative to group or residential treatment; and</li> <li>7. The youth must have an adult/parental figure able to assume the long term parenting role and to actively participate with MTFC service providers for the duration of treatment.</li> </ol>
<b>Initial Authorizations</b>	<p>Authorization may be up to thirty-one (31) units per month by MHCC for three (3) months.</p> <p>Unit = One (1) day.</p>
<b>Re-Authorization</b>	<p>Re-authorize may be up to thirty-one (31) units per month with approval from the MHS1 up to six (6) months.</p> <p>Unit = One (1) day.</p> <p>Any request for re-authorization beyond nine (9) months must be approved by the Clinical Psychologist.</p>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

<b>Continuing Stay Criteria</b>	<p><u>All</u> of the following criteria are met as determined by treatment team review:</p> <ol style="list-style-type: none"> <li>1. All admission criteria continue to be met;</li> <li>2. Services are being provided as indicated in the CSP and MHTP and there are regular and timely assessments and documentation of youth/family response to services. Timely and appropriate modifications are made to services and plan as needed;</li> <li>3. The youth continues to exhibit willful delinquent and disruptive behavior indicating that MTFC is the most appropriate means of addressing those needs; and</li> <li>4. There is a reasonable expectation that within four (4) weeks the youth/family will continue to make significant progress toward reaching the treatment goals identified at the outset of MTFC.</li> </ol>
<b>Discharge Criteria</b>	<p><u>One</u> (1) of the following discharge must be met:</p> <ol style="list-style-type: none"> <li>1. The youth is no longer eligible for CAMHD services. As part of discharge, the MHCC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible;</li> <li>2. The treatment team determines that service is no longer needed as there is a decrease in the identified problematic behavior and/or an increase in the developmentally appropriate pro-social behavior in home, family, school, and community settings;</li> <li>3. The youth/family no longer wants to participate in this service and revokes consent with no imminent danger to self or others;</li> <li>4. Youth has demonstrated minimal or no progress toward treatment goals for a two (2) month period and appropriate modifications of the treatment plan have been made and implemented with no significant success, suggesting the youth is not benefiting from this services at this time;</li> <li>5. Youth exhibits new symptoms and/or maladaptive behaviors which cannot be safely and effectively address through this service as determined by CSP team;</li> <li>6. The youth has made progress on goals and objectives outlined in the CSP/MHTP such that he or she is able to transition back to the family setting; and</li> <li>7. The youth has the knowledge and supports necessary to sustain treatment outcomes and to support a successful transition to a permanent placement.</li> </ol>
<b>Service Exclusions</b>	<ol style="list-style-type: none"> <li>1. No treatment outside the MTFC program should co-occur during placement with the exception of medication management, as needed.</li> <li>2. Not offered at the same time as any out-of-home service.</li> <li>3. Not offered at the same time as any Intensive In-Home Intervention, Multisystemic Therapy, Functional Family</li> </ol>

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

	Therapy or intensive outpatient services except where the youth will be transitioned out of the MTFC and into the identified service within thirty (30) days referral.
<b>Clinical Exclusions</b>	<ol style="list-style-type: none"><li>1. Youth for whom a primary caregiver cannot be identified despite extensive efforts to locate all extended family, adult friends, and other potential surrogate caregivers.</li><li>2. Youth whose cognitive capacity prevents effective working with MTFC's point and level system.</li><li>3. Youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior.</li><li>4. Youth with a currently active thought disorder or other severe mental illness. Once stable, youth who otherwise meet the eligibility criteria may be referred into the program.</li></ol>

### Staffing Requirements

In addition to the staffing requirements listed in the general standards, these staff requirements must also be followed. If the standards referenced here differ from those in the general standards, these staffing requirements will supersede the general standards.

1. Foster parents must be licensed with the Department of Human Services prior to initiating services.
2. In addition to all requirements for licensure, Contractor will ensure that all MTFC families receive at least twenty (20) hours of initial orientation to include: orientation to the contractor agency, child management, and participation in treatment team meetings/discussions before the first youth is placed in the foster home. On an on-going basis, families shall receive at least twenty (20) hours of training annually on topics related to mental health special needs youth.
3. Foster parents (at least one parent) are required to receive at least two (2) hours a month supervision from the MTFC clinical supervisor.
4. The MTFC clinical supervisor must be a QMHP who oversees all MTFC staff and is responsible for all clinical decisions made.
5. The individual therapist must be an MHP.
6. The family therapist must be an MHP.
7. Peer Counselor is a paraprofessional or preferably a credentialed peer counselor.
8. The PDR caller will typically be a paraprofessional with previous foster care or data entry experience.

### Clinical Operations

In addition to the clinical operation requirements listed in the general standards, these requirements must also be followed. If the standards referenced here differ from those in the general standards, these clinical operation requirements will supersede the general standards.

1. Services are available twenty-four (24) hours a day, seven (7) days a week.
2. Prior to placement program provides foster parent with a written plan for providing emergency and psychiatric care.
3. The agency has established procedures/protocols in place for managing crises effectively and efficiently through the direct interventions of its professional staff. Included in these procedures are descriptions of methods for handling emergency and crisis situations and triaging youth who require more intensive interventions. Request for police assistance or crisis hotline assistance are limited to situations of imminent risk of harm to self or others.

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

4. Service delivery must be preceded by a thorough assessment of the youth and their family so that an appropriate and effective treatment plan can be developed. A complete intake, screening, and assessment are provided to each youth prior to or upon admission.
5. Program has an intake process that includes integration of information available on youth/family in the treatment planning to ensure appropriate and effective treatment. Program also has an established protocol for orienting youth to the program.
6. The home may have biological and/or adopted minor youth in the home and no more than one (1) foster youth in the home, unless a waiver is requested and approved by MTFC for a sibling group placed together. There shall be a minimum of one (1) adult at home whenever the youth(s) is present. The Contractor shall provide additional staff support as necessary.
7. The Contractor must have policies that ensure that foster parents plan for the youth's regular medical and dental services, and keep the provider agency informed of any health problems or any changes that adversely affect the youth in foster care.
8. At contract award, all Contractors of Therapeutic Foster Homes Services shall submit a list of foster families with all of the following information required on the Therapeutic Foster Home Profile Form (See Appendix B-15). Thereafter, biannually, and if necessary upon CAMHD's request, the Contractors shall update this report and submit any changes to the CAMHD Clinical Services Office, Utilization Management Section that shall maintain the information in accordance with all confidentiality requirements.
9. The Contractor shall have written policies and procedures and train staff on securing and storing medications; labeling and administering medications as ordered by a physician; recording medication administration, youth request for adjustment or change, and any side effects and notifying physician or advanced practice registered nurse immediately of possible side effects; and disposing of medications.
10. The Contractor must have clear procedures, which specify its approach to positive evidence-based behavior management and to evidence-based family therapy interventions. These procedures must clearly delineate methods to be used for the training and implementation of these evidence-based behavioral interventions.
11. Provider is to follow all applicable professional practice standards and ethical guidelines.
12. Eight (8) therapeutic passes are allowed per episode of care for each youth in the program to assist him/her in meeting the MHTP goals as defined in the general standards.
13. Up to seven (7) bed hold days may be used to reserve the bed for a youth who is absent from the program as defined in the general standards.
14. The Contractor must do a Summary Annual Assessment for SEBD eligible youth in their care at the time the annual assessment is due on youth who have received at least three (3) months of services from the Contractor. See Summary Annual Assessment performance standards in Section II, Part D.
15. Please see Section I General Standards for additional clinical operation requirements:
  - D. CAMHD Co-Occurring Disorders;
  - F. Referral Process for Services:
    - Referral Acceptance;
  - G. CAMHD Continuity of Care;
  - H. Staffing;
  - I. Supervision;
  - J. Evaluation of Staff Performance;
  - K. Credentialing Requirements;
  - N. Service Quality;
  - O. Minimum Reporting Requirements;
  - P. Risk Management:
    - Criminal, Child Abuse, and Background Screening;

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

- Safety;
- Restraints and Seclusion;
- Sentinel Events and Incidents;
- Police;
- V. Bed Hold and Therapeutic Passes:
  - Bed hold;
  - Therapeutic Pass.

### Documentation

1. In addition to the documentation requirements listed in the general standards, these requirements must also be followed. If the standards referenced here differ from those in the general standards, these documentation requirements will supersede the general standards.
2. Please see Section I General Standards for additional documentation requirements:
  - E. Service Planning:
    - Mental Health Treatment Plan including transition, crisis and discharge planning;
    - Discharge Summary;
  - M. Maintenance of Service Records;
  - O. Minimum Reporting Requirements:
    - Monthly Treatment and Progress Summary;
3. The foster parents shall maintain notes that provide a) a daily attendance log indicating the youth's presence or absence from the home including absences of twenty-four (24) hours or more b) daily progress notes as documentation of treatment progress, events or activities youth engaged in or developmental milestones achieved. These notes shall be fully dated and signed by the foster parent, originals of which shall be maintained in the youth's file within twenty-four (24) hours of service and in the agency's master youth file within seven (7) calendar days.
4. Provider must complete all documentation requirements specific to MTFC.



## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### L. THERAPEUTIC GROUP HOMES

<b>Definition</b>	Provide twenty-four (24) hour care and integrated evidence-based treatment to address behavioral, emotional, or systemic issues, which prevent youth from taking part in family or community life. Therapeutic Group Homes are designed for those whose needs can best be met in a structured, small group, community-based setting. The youth usually remain involved in community-based educational, recreational, and occupational activities. These homes typically provide services for four (4) to eight (8) youth per home. In this level of care, youth are supervised and provided services by professional and paraprofessional staff that have been recruited and trained to work with youth with emotional and behavioral challenges.
<b>Services Offered</b>	<ol style="list-style-type: none"> <li>1. Activities that support the development of age-appropriate daily living skills.</li> <li>2. Evidence-based interventions, including positive behavioral management.</li> <li>3. Medication monitoring.</li> <li>4. Individual Therapy at least one (1) time per week to address identified issues*.</li> <li>5. Group Therapy at least one (1) time per week unless contra indicated by evidence-based research*.</li> <li>6. Family Therapy at least two (2) times per month as indicated in youth's plan*.</li> <li>7. Integrated individualized substance abuse treatment and education as indicated in the youth's plan.</li> <li>8. Culturally relevant recreational and social group activities that are rooted in evidence-based treatment and that support the development of interpersonal relating and life skills through modeling and coaching.</li> </ol>
<b>Admission Criteria</b>	<p><u>All</u> of the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. The identified youth meets at least one (1) of the Service Eligibility criteria for CAMHD (as described in General Standards, Section A, Access &amp; Availability);</li> <li>2. The youth is registered with a Branch, and has an assigned MHCC;</li> <li>3. The youth must be between the ages of twelve (12) and eighteen (18) years of age;</li> <li>4. The youth has identified needs that can be best met in structured group setting. The youth is able to participate in educational, recreational and social activities outside the residence;</li> <li>5. The CSP identifies this service and measurable objectives for outcomes of this service prior to admission;</li> <li>6. There is a reasonable expectation that the youth can benefit from a therapeutic living program within two (2) months; and</li> <li>7. An adequate trial of active treatment at a less restrictive</li> </ol>

\* See performance standard for service referenced.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	level has been unsuccessful or given serious consideration and found to be inappropriate.
<b>Initial Authorizations</b>	Authorization may be up to thirty-one (31) units per month by the MHCC for two (2) months. Unit = One (1) day
<b>Re-Authorization</b>	Re-authorize may be up to thirty-one (31) units monthly with approval from MHS1.  Unit = One (1) day.  Any request for re-authorization beyond five (5) months must be approved by the Clinical Director.
<b>Continuing Stay Criteria</b>	<u>All</u> of the following criteria are met as determined by treatment team review: <ol style="list-style-type: none"> <li>1. Services/items are being provided as indicated in the CSP and MHTP and there are regular and timely assessments and documentation of youth/family response to services. Timely and appropriate modifications are made to services and plan as needed;</li> <li>2. The youth continues to have specific needs that indicate this service is the most appropriate means of addressing those needs;</li> <li>3. The youth's progress is not sufficient to allow movement to a less restrictive level of care; and</li> <li>4. There is a reasonable expectation that the youth will continue to make progress within the next month toward reaching the goals and objectives identified in the youth's MHTP and CSP.</li> </ol>
<b>Discharge Criteria</b>	<u>One</u> (1) of the following criteria must be met: <ol style="list-style-type: none"> <li>1. The youth is no longer eligible for CAMHD services. As part of discharge, the MHCC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible;</li> <li>2. The youth/family no longer wants to participate in this service and revokes consent with no danger to self or others;</li> <li>3. Targeted symptoms and/or maladaptive behaviors have abated to a level of severity which no longer requires this level of care as documented by attainment of goals in the MHTP and CSP;</li> <li>4. Youth has demonstrated minimal or no progress toward treatment goals for a two (2) month period and appropriate modifications of the MHTP has been made and implemented with no significant success and the CSP team determines that the youth is not benefiting from this service at this time; and</li> <li>5. Youth exhibits new symptoms and/or maladaptive behaviors which cannot be safely and effectively addressed through</li> </ol>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	this service as determined by CSP team.
<b>Service Exclusions</b>	<ol style="list-style-type: none"><li>1. Not offered at the same time as any out-of-home services.</li><li>2. Not offered at the same time as any Intensive In-Home Intervention, Multisystemic, Function Family Therapy or Intensive Outpatient service, except in cases where the youth has a planned discharge from Therapeutic Group Home within thirty (30) days of referral.</li></ol>
<b>Clinical Exclusions</b>	Youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior. Once stable, youth who otherwise meet the eligibility criteria may be referred into the program.

### Staffing Requirements:

In addition to the staffing requirements listed in the general standards, these staff requirements must also be followed. If the standards referenced here differ from those in the general standards, these staffing requirements will supersede the general standards.

1. Therapeutic group home staff must be supervised by a QMHP with experience in evidence-based treatments. Staff includes: paraprofessional, MHP and QMHP.
2. At a minimum, two (2) staff shall be on duty per shift in each living unit, with one (1) staff awake during overnight shifts.
3. A ratio of not less than one (1) staff to four (4) youth is maintained at all times, however two (2) staff must be on duty at all times.
4. At least one (1) staff member per shift is required to have a current CPR and First Aid certification.
5. Staffing schedules shall reflect overlap in shift hours to accommodate information exchange for continuity of youth treatment, adequate numbers of staff reflective of the tone of the unit, appropriate staff gender mix, and the consistent presence and availability of a professional staff.
6. A licensed registered nurse is on staff to establish the system of operation for administering or supervising residents' medications, and medical needs or requirements, monitoring the residents' response to medications, tracking and attending to dental and medical needs, and training staff to administer medications and proper protocols.
7. The program is required to have a psychiatrist or psychologist that provides twenty-four (24) hour on-call coverage, seven (7) days a week.
8. Provider is to follow all applicable professional practice standards and ethical guidelines.

### Clinical Operations

In addition to the clinical operation requirements listed in the general standards, these requirements must also be followed. If the standards referenced here differ from those in the general standards, these clinical operation requirements will supersede the general standards.

1. Services are available twenty-four (24) hours a day, seven (7) days a week.
2. The program will not exceed eight (8) youth per residence.
3. The program must adhere to all applicable facility licensing requirements/regulations.
4. The program will have an intake process that includes introducing the youth and family to the program, review and assessment of existing documentation to integrate into the treatment plan, crisis plan, and de-escalation plan or behavioral support plan within their milieu.
5. The program actively engages the youth in planned, structured, therapeutic activities, rooted in evidence-based treatment, throughout the day, seven (7) days a week. There is a predictable

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

and orderly routine that allows the youth to develop and enhance interpersonal skills and behaviors.

6. The physical setting is home-like and furnished appropriate to the youths' developmental age. The youth are encouraged to appropriately decorate and maintain their personal space.
7. Youth who are unable to attend a regularly scheduled day activities (e.g. school, work) must be provided supervision and therapeutic structure by program staff.
8. Program must provide schools with emergency contact information for day staff response in case of illness or incident within the school setting.
9. Families are actively involved and participate in team meetings, program events, therapy sessions, and other activities. They are engaged in opportunities to gain knowledge and practice of what works in the program setting that can be transferred to the home and community environment.
10. The therapeutic group home program has clear procedures, which specify its approach to positive evidence-based behavior management. These procedures must clearly delineate methods of training and implementation of positive evidence-based behavioral interventions.
11. The Contractor has established procedures/protocols in place for managing crises effectively and efficiently through the direct interventions of its professional clinical and medical staff. Included in these procedures are descriptions of methods for handling emergency and crisis situations and triaging youth who require more intensive interventions. Request for police assistance or crisis hotline assistance are limited to situations of imminent risk of harm to self or others.
12. The Contractor must do a Summary Annual Assessment for SEBD eligible youth in their care at the time the annual assessment is due on youth who have received at least three (3) months of services from the Contractor. See Summary Annual Assessment performance standards in Section II, Part D.
13. Six (6) therapeutic passes are allowed per episode of care for each youth in the program to assist him/her in meeting the MHTP goals as defined in the general standards.
14. Up to seven (7) bed hold days may be used to hold the bed of a youth who is absent from the program as defined in the general standards.
15. Please see Section I General Standards for additional clinical operation requirements:
  - D. CAMHD Co-Occurring Disorders;
  - F. Referral Process for Services:
    - Referral Acceptance;
  - G. CAMHD Continuity of Care;
  - H. Staffing;
  - I. Supervision;
  - J. Evaluation of Staff Performance;
  - K. Credentialing Requirements;
  - L. Medication Monitoring / Tracking;
  - N. Service Quality;
  - O. Minimum Reporting Requirements;
  - P. Risk Management:
    - Criminal, Child Abuse, and Background Screening;
    - Safety;
    - Restraints and Seclusion;
    - Sentinel Events and Incidents;
    - Police;
  - V. Bed Hold and Therapeutic Passes:
    - Bed hold;
    - Therapeutic Pass.

### Documentation

1. In addition to the documentation requirements listed in the general standards, these requirements must also be followed. If the standards referenced here differ from those in the general standards, these documentation requirements will supersede the general standards.
2. Please see Section I General Standards for documentation requirements:
  - E. Service Planning:
    - Mental Health Treatment Plan including transition, crisis and discharge planning;
    - Discharge Summary;
  - M. Maintenance of Service Records:
    - Progress Notes;
  - O. Minimum Reporting Requirements:
    - Monthly Treatment and Progress Summary.
3. A daily attendance log indicating the youth's presence or absence from the home including absences of twenty-four (24) hours or more and a daily progress notes as documentation of treatment progress, events or activities youth engaged in or developmental milestones achieved. These notes shall be fully dated and signed by the writer and supervisor if needed. Originals of which shall be maintained in the agency's master youth file within 24 hours of service.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### M. INDEPENDENT LIVING PROGRAMS 18 – 21

<b>Definition</b>	Provide twenty-four (24) hour care and integrated evidence-based treatment planning to address the behavioral, emotional and/or systemic issues that prevent young adults from living independently in the community. Independent Living Programs are designed to assist residents in developing the skills necessary to live independently in the community upon discharge. The Independent Living Program is responsible for linking young adults to educational, vocational, employment, health services and community resources. At admission, residents are not necessarily involved in community-based educational, recreational, and/or occupational activities during the day. Independent Living Programs typically provide services for four (4) to eight (8) young adults per home. In this level of care, young adults are supervised and provided services by professionals and paraprofessionals that have been recruited and trained to work with transitioning adults.
<b>Services Offered</b>	<ol style="list-style-type: none"> <li>1. The program provides activities that support the development of independent living skills.</li> <li>2. An evidenced-based curriculum is utilized to ensure timely acquisitions of skills need for independent living.</li> <li>3. Evidence-based interventions, including positive behavioral support.</li> <li>4. Medication monitoring.</li> <li>5. Individual Therapy at least one (1) time per week to address identified issues *.</li> <li>6. Group Therapy at least one (1) time per week to address identified issues, unless clinically contraindicated. *</li> <li>7. Family Therapy as indicated in young adult's plan*.</li> <li>8. Integrated individualized substance abuse treatment and education as indicated in the young adult's plan.</li> <li>9. Social/recreational group activities that are rooted in evidence-based treatment.</li> </ol>
<b>Admission Criteria</b>	<p><u>All</u> of the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. The identified young adult meets at least one (1) of the Service Eligibility criteria for CAMHD (as described in General Standards, Section A, Access &amp; Availability);</li> <li>2. The young adult is registered with a Branch, and has an assigned MHCC;</li> <li>3. The young adult must be a least eighteen (18) and younger than twenty-one (21) years of age;</li> <li>4. The young adult has identified needs that can best be met in a structured group setting. The young adult is able to participate in educational, vocational, employment, recreational, and social activities outside the residence;</li> <li>5. An adequate trial of active treatment at a less restrictive level has been unsuccessful or given serious consideration but found to be inappropriate;</li> </ol>

\* See performance standard for service referenced.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<ol style="list-style-type: none"> <li>6. There is a reasonable expectation that the young adult can benefit from an Independent Living Program within five (5) months; and</li> <li>7. The CSP identifies this service and measurable objectives for outcomes of this service prior to admission.</li> </ol>
<b>Initial Authorizations</b>	<p>Authorization may be up to thirty-one (31) units per month by MHCC for two (2) months.</p> <p>Unit = One (1) day</p>
<b>Re-Authorization</b>	<p>Re-authorization may be up to thirty-one (31) units per month with approval from the MHS1 for three (3) months.</p> <p>Any request for re-authorization beyond five (5) months must be approved by the Clinical Director.</p> <p>Unit = One (1) day</p>
<b>Continuing Stay Criteria</b>	<p><u>All</u> of the following criteria are met as determined by treatment team review:</p> <ol style="list-style-type: none"> <li>1. Services are being provided as indicated in the MHTP and CSP and there are regular and timely assessments and documentation of young adult's response to services. Timely and appropriate modifications are made to services and plan as needed;</li> <li>2. The young adult continues to have specific needs that indicate that ILP is the most appropriate means of addressing those needs;</li> <li>3. The young adult's progress is not sufficient to allow movement to a less restrictive level of care; and</li> <li>4. There is a reasonable expectation that the young adult will continue to make progress within the next month toward reaching the goals and objectives identified in the youth's MHTP and CSP.</li> </ol>
<b>Discharge Criteria</b>	<p><u>One</u> (1) of the following criteria must be met:</p> <ol style="list-style-type: none"> <li>1. The young adult is no longer eligible for CAMHD services. As part of discharge, the MHCC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible;</li> <li>2. The young adult no longer wants to participate in this service and revokes consent with no danger to self or others;</li> <li>3. Young adult has demonstrated minimal or no progress toward treatment goals for a two (2) month period and appropriate modifications of MHTP have been made and implemented with no significant success, and the CSP team determines that the young adult is not benefiting from this service at this time;</li> <li>4. Young adult exhibits new symptoms or maladaptive behaviors which cannot be safely and effectively addressed</li> </ol>

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

	<p>through this service as determined by the CSP team;</p> <ol style="list-style-type: none"><li>5. There is improved, sustainable emotional, behavioral, and social functioning as evidenced by improved independent living skills, pro-social peer affiliations, and participation in community social/ recreational activities and documented attainment of goals in the MHTP and CSP;</li><li>6. The young adult reaches a level of functioning that allows for transition to independent living; and</li><li>7. The young adult has the knowledge and supports necessary to sustain treatment outcomes and/or to support a successful transition to live in the community.</li></ol>
<b>Service Exclusions</b>	<ol style="list-style-type: none"><li>1. Not offered at the same time as any out-of-home placements.</li><li>2. Not offered at the same time as Intensive In-Home Intervention, Outpatient services, except in cases where the youth has a planned discharge from Independent Living Program within thirty (30) days of referral.</li></ol>
<b>Clinical Exclusions</b>	Youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior. Once stable, youth who otherwise meet the eligibility criteria may be referred into the program.

### Staffing Requirements:

In addition to the staffing requirement listed in the general standards, these staff requirements must also be followed. If the standards referenced here differ from those in the general standards, these staffing requirements will supersede the general standards.

1. At minimum, two (2) direct care staff shall be on duty per shift in each living unit, with one (1) staff awake during overnight shifts.
2. A ratio of one (1) staff to four (4) residents is maintained at all times, however two (2) staff must be on duty at all times.
3. At least one (1) staff member per shift is required to have a current CPR and First Aid certification.
4. A licensed registered nurse is on staff to establish the system of operation for administering or supervising residents' medication and medical needs or requirements, monitoring the residents' response to medications, tracking and attending to dental and medical needs, and training staff to administer medication and proper protocols.
5. The program provides a Transition Facilitator that is assigned to each young adult enrolled the program. Transition Facilitators must be, at minimum, a MHP.
6. The QMHP develops or supervises the development of the MHTP.
7. The Transition Facilitator works with the young adult to develop a Transition Support Plan (TSP) that outlines measurable independent living goals and objectives to be achieved in the program.
8. Independent Living Program staff must be supervised by a QMHP with experience in evidence-based treatments. Staff includes: Transition Facilitators and paraprofessionals.
9. Staffing schedules shall reflect overlap in shift hours to accommodate information exchange for continuity of treatment, adequate numbers of staff reflective of the tone of the unit, appropriate staff gender mix, and the consistent presence and availability of a professional staff.



10. The program is required to have a psychiatrist or psychologist provide twenty-four (24) hour on-call coverage, seven (7) days a week.

### **Clinical Operations**

In addition to the clinical operation requirements listed in the general standards, these requirements must also be followed. If the standards referenced here differ from those in the general standards, these clinical operation requirements will supersede the general standards.

1. Services are available twenty-four (24) hours a day, seven (7) days a week.
2. The program will not exceed eight (8) young adults per residence.
3. Program has an intake process that includes integration of information available on young adults/family in the treatment planning to ensure appropriate and effective treatment. Program also has an established protocol for orienting young adults to the program.
4. Provider is to follow all applicable professional practice standards and ethical guidelines.
5. The program provides professional staff during the day to be able to implement programmatic components reflective of resident's needs that are not in school, vocational programming or work.
6. The program actively engages the young adult in planned, structured, therapeutic activities, rooted in evidence-based treatment, throughout the day, seven (7) days a week. There is a predictable and orderly routine that allows the young adult to develop and enhance interpersonal skills and behaviors.
7. The physical setting is home-like and furnished appropriate to the young adult's developmental age. The young adults are encouraged to appropriately decorate and maintain their personal space.
8. As appropriate, family involvement is supported through participation in team meetings, program events, therapy sessions, etc.
9. Program provides linkages, transportation and support to attend specialty programs (e.g. N.A., A.A., etc.) for young adults who present dependency issues while at the program as outlined in the MHTP/CSP.
10. The Contractor has established procedures/protocols in place for managing crises effectively and efficiently through the direct interventions of its professional clinical and medical staff. Included in these procedures are descriptions of methods for handling emergency and crisis situations and triaging youth who require more intensive interventions. Request for police assistance or crisis hotline assistance are limited to situations of imminent risk of harm to self or others.
11. The Contractor must do a Summary Annual Assessment for SEBD eligible young adults in their care at the time the annual assessment is due on young adult who have received at least three (3) months of services from the Contractor. See Summary Annual Assessment performance standards in Section II, Part D.
12. Two (2) therapeutic passes are allowed per episode of care for each young adult in the program to assist him/her in meeting the MHTP goals as defined in the general standards.
13. Up to seven (7) bed hold days may be used to reserve the bed for a young adult who is absent from the program as defined in the general standards.
14. Please see Section I General Standards for additional clinical operation requirements:
  - D. CAMHD Co-Occurring Disorders;
  - F. Referral Process for Services:
    - Referral Acceptance;
  - G. CAMHD Continuity of Care;
  - H. Staffing;
  - I. Supervision;
  - J. Evaluation of Staff Performance;

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

- K. Credentialing Requirements;
- L. Medication Monitoring / Tracking;
- N. Service Quality;
- O. Minimum Reporting Requirements;
- P. Risk Management:
  - Criminal, Child Abuse, and Background Screening;
  - Safety;
  - Restraints and Seclusion;
  - Sentinel Events and Incidents;
  - Police;
- V. Bed Hold and Therapeutic Passes:
  - Bed hold;
  - Therapeutic Pass.

### Documentation

In addition to the documentation requirements listed in the general standards, these requirements must also be followed. If the standards referenced here differ from those in the general standards, these documentation requirements will supersede the general standards.

1. Please see Section I General Standards for additional documentation requirements:
  - E. Service Planning:
    - Mental Health Treatment Plan including transition, crisis and discharge planning;
    - Discharge Summary;
  - M. Maintenance of Service Records:
    - Progress Notes;
  - O. Minimum Reporting Requirements:
    - Monthly Treatment and Progress Summary.
2. The Independent Living Program shall provide a daily progress note as documentation of treatment progress and/or significant events, activities, or milestones achieved. These notes shall be fully dated and signed by the writer and supervisor if needed. Originals of which shall be maintained in the agency's master young adult file within twenty-four (24) hours of service.
3. A TSP must be written by the Transition Facilitator within two (2) week of admission to the program. The TSP must cover the how the young adult will be supported in developing their own goal around: Housing, Employment, Education, Social, Financial, and Health domains.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### N. INDEPENDENT LIVING PROGRAMS 16–18

<b>Definition</b>	Provide twenty-four (24) hour care and integrated evidence-based treatment planning to address the behavioral, emotional and/or systemic issues that prevent youth from living independently in the community. Independent Living Programs are designed to assist transitioning youth in need of emotional and behavioral supports to develop the skills necessary to live independently in the community upon discharge. The Independent Living Program links youth to educational, vocational, employment, health services and community resources. At admission, the youth are may be involved in community-based educational, recreational, and/or occupational activities. Independent Living Programs typically provide services for four (4) to eight (8) youth per home. In this level of care, youth are supervised and provided services by professional and paraprofessionals that have been recruited and trained to work with transitioning youth.
<b>Services Offered</b>	<ol style="list-style-type: none"> <li>1. The program provides activities that support the development of independent living skills.</li> <li>2. An evidenced-based curriculum is utilized to ensure timely acquisitions of skills need for independent living.</li> <li>3. Evidence-based interventions, including positive behavioral support.</li> <li>4. Medication monitoring.</li> <li>5. Individual Therapy at least one (1) time per week to address identified issues*.</li> <li>6. Group Therapy at least one (1) time per week to address identified issues, unless clinically contraindicated*.</li> <li>7. Family Therapy at least two (2) times per month as indicated in youth's plan*.</li> <li>8. Integrated individualized substance abuse treatment and education as indicated in the youths plan.</li> <li>9. Social/recreational group activities that are rooted in evidence-based treatment.</li> </ol>
<b>Admission Criteria</b>	<p><u>All</u> of the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. The identified youth meets at least one (1) of the Service Eligibility criteria for CAMHD (as described in General Standards, Section A, Access &amp; Availability);</li> <li>2. The youth is registered with a Branch, and has an assigned MHCC;</li> <li>3. The youth must be between the ages of sixteen (16) and eighteen (18) years of age;</li> <li>4. The youth has identified needs that can best be met in a structured group setting. The youth is able to participate in educational, vocational, employment, recreational and social activities outside the residence;</li> <li>5. The CSP identifies this service and measurable objectives for outcomes of this service prior to admission;</li> </ol>

\* See performance standard for service referenced.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<ol style="list-style-type: none"> <li>6. There is a reasonable expectation that the youth can benefit from an Independent Living Program within five (5) months; and</li> <li>7. An adequate trial of active treatment at a less restrictive level has been unsuccessful or given serious consideration and found to be inappropriate.</li> </ol>
<b>Initial Authorizations</b>	<p>Authorization may be up to thirty-one (31) units per month by the MHCC for two (2) months.</p> <p>Unit = One (1) day</p>
<b>Re-Authorization</b>	<p>Re-authorization may be up to thirty-one (31) units monthly with approval of the MHS1 for three (3) months.</p> <p>Unit = One (1) day</p> <p>Any request for re-authorization beyond five (5) months must be approved by the Clinical Director.</p>
<b>Continuing Stay Criteria</b>	<p><u>All</u> of the following criteria are met as determined by treatment team review:</p> <ol style="list-style-type: none"> <li>1. Services/items are being provided as indicated in the MHTP and CSP and there are regular and timely assessments and documentation of youth/family response to services. Timely and appropriate modifications are made to services and plan as needed;</li> <li>2. The youth continues to have specific needs that indicate that ILP is the most appropriate means of addressing those needs;</li> <li>3. The youth's progress is not sufficient to allow movement to a less restrictive level of care; and</li> <li>4. There is a reasonable expectation that the youth will continue to make progress within the next month toward reaching the goals and objectives identified in the youth's MHTP and CSP.</li> </ol>
<b>Discharge Criteria</b>	<p><u>One</u> (1) of the following criteria must be met:</p> <ol style="list-style-type: none"> <li>1. The youth is no longer eligible for CAMHD services. As part of discharge, the MHCC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible;</li> <li>2. The youth/family no longer wants to participate in this service and revokes consent with no danger to self or others;</li> <li>3. Youth has demonstrated minimal or no progress toward treatment goals for a two (2) month period and appropriate modifications of the MHTP have been made and implemented with no significant success and the CSP team determines that the youth is not benefiting from this service at this time;</li> </ol>

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

	<ol style="list-style-type: none"><li>4. Youth exhibits new symptoms and/or maladaptive behaviors which cannot be safely and effectively addressed through this service as determined by CSP team;</li><li>5. The youth reaches a level of functioning that allows for transition to independent living; and</li><li>6. The youth has the knowledge and supports necessary to sustain treatment outcomes and/or to support a successful transition to live in the community.</li></ol>
<b>Service Exclusions</b>	<ol style="list-style-type: none"><li>1. Not offered at the same time as any out-of-home services.</li><li>2. Not offered at the same time as any Intensive In-Home Intervention or Intensive Outpatient service, except in cases where the youth has a planned discharge from Independent Living Program within thirty (30) days of referral.</li></ol>
<b>Clinical Exclusions</b>	Youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior. Once stable, youth who otherwise meet the eligibility criteria may be referred to the program.

### Staffing Requirements:

In addition to the staffing requirements listed in the general standards, these staff requirements must also be followed. If the standards referenced here differ from those in the general standards, these staffing requirements will supersede the general standards.

1. At minimum, two (2) direct care staff shall be on duty per shift in each living unit, with one (1) staff awake during overnight shifts.
2. A ratio of one (1) staff to four (4) residents is maintained at all times, however two (2) staff must be on duty at all times.
3. At least one (1) staff member per shift is required to have a current CPR and First Aid certification.
4. A licensed registered nurse is on staff to establish the system of operation for administering or supervising residents' medication and medical needs or requirements, monitoring the residents' response to medications, tracking and attending to dental and medical needs, and training staff to administer medication and proper protocols.
5. The program provides a Transition Facilitator that is assigned to each youth enrolled the program. Transition Facilitators must, at minimum, be a MHP.
6. The QMHP develops or supervises the development of the Mental Health Treatment plan.
7. The Transition Facilitator works with the youth to develop a Transition Support Plan (TSP) that outlines measurable independent living goals and objectives to be achieved in the program.
8. Independent Living Program staff must be supervised by a QMHP with experience in evidence-based treatments. Staff includes: Transition Facilitators and paraprofessionals.
9. The program provides professional staff during the day to be able to implement programmatic components reflective of resident's needs, who are not in school, vocational programming or work.
10. Staffing schedules shall reflect overlap in shift hours to accommodate information exchange for continuity of treatment, adequate numbers of staff reflective of the tone of the unit, appropriate staff gender mix, and the consistent presence and availability of a professional staff.
11. The program must adhere to all applicable facility licensing requirements/regulations.

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

12. The program is required to have a psychiatrist or psychologist provides twenty-four (24) hours on-call coverage, seven (7) days a week.

### Clinical Operations

In addition to the clinical operation requirements listed in the general standards, these requirements must also be followed. If the standards referenced here differ from those in the general standards, these clinical operation requirements will supersede the general standards.

1. Services are available twenty-four (24) hours a day, seven (7) days a week.
2. The program will not exceed eight (8) youth per residence.
3. Program has an intake process that includes integration of information available on youth/family in the treatment planning to ensure appropriate and effective treatment. Program also has an established protocol for orienting youth to the program.
4. Provider is to follow all applicable professional practice standards and ethical guidelines.
5. The program actively engages the youth in planned, structured, culturally relevant therapeutic activities, rooted in evidence-based treatment, throughout the day, seven (7) days a week. There is a predictable and orderly routine that allows the youth to develop and enhance interpersonal skills and behaviors.
6. Program must provide schools with emergency contact information for day staff response in case of illness or incident within the school setting.
7. Families are actively involved and participate in team meetings, program events, and therapy sessions. Families are actively engaged in ongoing activities with their youth and program staff to gain knowledge of and have the opportunity to practice interventions that have been proven effective for their youth within the program setting that can support success for youth in the community.
8. The physical setting is home-like and furnished appropriate to the youth's developmental age. The youth are encouraged to appropriately decorate and maintain their personal space.
9. Program provides linkage, transportation and support to attend specialty programs (e.g. N.A., A.A., etc.) for youth who present dependency issues while in the program as outlined in the MHTP/CSP.
10. The Contractor has established procedures/protocols in place for managing crises effectively and efficiently through the direct interventions of its professional clinical and medical staff. Included in these procedures are descriptions of methods for handling emergency and crisis situations and triaging youth who require more intensive interventions. Request for police assistance or crisis hotline assistance are limited to situations of imminent risk of harm to self or others.
11. The Contractor must do a Summary Annual Assessment for SEBD eligible youth in their care at the time the annual assessment is due on youth who have received at least three (3) months of services from the Contractor. See Summary Annual Assessment performance standards in Section II, Part D.
12. Two (2) therapeutic passes are allowed per episode of care for each youth in the program to assist him/her in meeting the MHTP goals as defined in the general standards.
13. Up to seven (7) bed hold days may be used to reserve the bed for a youth who is absent from the program as defined in the general standards.
14. Please see Section I General Standards for additional clinical operation requirements:
  - D. CAMHD Co-Occurring Disorders;
  - F. Referral Process for Services:
    - Referral Acceptance;
  - G. CAMHD Continuity of Care;
  - H. Staffing;
  - I. Supervision;

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

- J. Evaluation of Staff Performance;
- K. Credentialing Requirements;
- L. Medication Monitoring / Tracking;
- N. Service Quality;
- O. Minimum Reporting Requirements;
- P. Risk Management:
  - Criminal, Child Abuse, and Background Screening;
  - Safety;
  - Restraints and Seclusion;
  - Sentinel Events and Incidents;
  - Police;
- V. Bed Hold and Therapeutic Passes:
  - Bed hold;
  - Therapeutic Pass.

### Documentation

In addition to the documentation requirements listed in the general standards, these requirements must also be followed. If the standards referenced here differ from those in the general standards, these documentation requirements will supersede the general standards.

1. Please see Section I General Standards for additional documentation requirements:
  - E. Service Planning:
    - Mental Health Treatment Plan including transition, crisis and discharge planning;
    - Discharge Summary;
  - M. Maintenance of Service Records:
    - Progress Notes;
  - O. Minimum Reporting Requirements:
    - Monthly Treatment and Progress Summary.
2. The Independent Living Program shall provide a daily progress note as documentation of treatment progress and/or significant events, activities, or milestones achieved. These notes shall be fully dated and signed by the writer and supervisor if needed. Originals of which shall be maintained in the agency's master youth file within 24 hours of service.
3. A TSP must be written by the Transition Facilitator within two (2) week of admission to the program. The TSP must cover the how the youth will be supported in developing their own goal around: Housing, Employment, Education, Social, Financial, and Health domains

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### O. COMMUNITY-BASED RESIDENTIAL LEVEL III

<b>Definition</b>	<p>Provide twenty-four (24) hour care and integrated service planning that addresses the behavioral, emotional and/or family problems, which prevent the youth from taking part in family and/or community life. These programs are designed for those youth whose needs can best be met in a structured program of small group living that includes onsite educational programs and highly structured therapeutic activities. Community-based Residential programs may be specialized (e.g., substance abuse).</p> <p>Community-Based Residential programs provide therapy, support, and assistance to the youth and the family to enhance participation in group living and community activities, increase positive personal and interpersonal skills and behaviors and to meet the youth's developmental needs.</p>
<b>Services Offered</b>	<ol style="list-style-type: none"><li>1. Evidenced based treatment interventions and milieu-based programming per the youth's MHTP.</li><li>2. Opportunities for the youth to engage in age-appropriate structured and community-based recreational activities.</li><li>3. Medication management.</li><li>4. Individual Therapy at least one (1) time per week to address identified issues .</li><li>5. Group Therapy at least one (1) time per week to address identified issues, unless clinically contraindicated*.</li><li>6. Family Therapy at least two (2) times per month as indicated in youth's plan*.</li><li>7. On-site educational program that addresses the educational goals and objectives identified in the youth's IEP (if applicable).</li><li>8. Integrated individualized substance abuse counseling and education as indicated in youth's plan.</li><li>9. Structured pre-vocational and vocational training activities as applicable.</li></ol>
<b>Admission Criteria</b>	<p><u>All</u> of the following criteria must be met:</p> <ol style="list-style-type: none"><li>1. The identified youth meets at least one (1) Service Eligibility criteria for CAMHD (as described in General Standards, Section A, Access &amp; Availability);</li><li>2. The youth is registered with a Branch, and has an assigned MHCC;</li><li>3. The youth must be between the ages of twelve (12) to eighteen (18) years of age;</li><li>4. An adequate trial of active treatment in a less restrictive setting has been unsuccessful or given serious consideration and found to be inappropriate;</li></ol>

\* See performance standard for service referenced.



## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<ol style="list-style-type: none"> <li>5. The youth consistently demonstrates severe emotional and behavioral problems such that they cannot be safely managed in a less restrictive setting;</li> <li>6. There is a reasonable expectation that the youth can benefit from this services within three (3) to five (5) months; and</li> <li>7. The CSP identifies this service and measurable objectives for outcomes of this service prior to admission.</li> </ol>
<b>Initial Authorizations</b>	<p>Authorization may be up to thirty-one (31) units per month for a maximum of two (2) months by the MHCC.</p> <p>Unit = one (1) day</p>
<b>Re-Authorization</b>	<p>Re-authorization may be up to thirty-one (31) units monthly for a maximum of three (3) months with approval from the MHS1.</p> <p>Maximum stay of five (5) months.</p> <p>Unit = one (1) day</p> <p>Any request for re-authorization beyond five (5) months must be approved by the Clinical Director.</p>
<b>Continuing Stay Criteria</b>	<p><u>All</u> of the following criteria are met as determined by treatment team review:</p> <ol style="list-style-type: none"> <li>1. All admission criteria continue to be met;</li> <li>2. Services/items are being provided as indicated in the CSP and MHTP and there are regular and timely assessments and documentation of youth/family response to services. Timely and appropriate modifications are made to services and plans as needed;</li> <li>3. The youth continues to have specific needs that indicate that this is the most appropriate means of addressing those needs; and</li> <li>4. There is a reasonable expectation that the youth can continue to make progress in achieving his/her defined measurable treatment goals and objectives as identified in the youth's MHTP within the next month.</li> </ol>
<b>Discharge Criteria</b>	<p><u>One</u> (1) of the following criteria must be met:</p> <ol style="list-style-type: none"> <li>1. The youth is no longer eligible for CAMHD services. As part of discharge, the MHCC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible;</li> <li>2. The youth/family no longer wants to participate in this service and revokes consent with no imminent danger to self or others;</li> <li>3. Targeted symptoms or behaviors have abated to a level of severity which no longer requires this level of care as documented by attainment of goals in the MHTP and CSP;</li> </ol>

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

	<ol style="list-style-type: none"><li>4. Youth reaches a level of functioning that allows for transition to a lower level of service to continue treatment;</li><li>5. Youth has demonstrated minimal or no progress toward treatment goals for a two (2) month period and appropriate modifications of the MHTP have been made and implemented with no significant success and the CSP team determines that the youth is not benefiting from this service at this time; and</li><li>6. Youth exhibits new symptoms and/or maladaptive behaviors which cannot be safely and effectively addressed through this service.</li></ol>
<b>Service Exclusions</b>	<ol style="list-style-type: none"><li>1. Not offered at the same time as any out-of-home services.</li><li>2. Not offered at the same time as any Intensive In-Home Intervention, Multisystemic, Functional Family Therapy or Intensive Outpatient services except where the youth will be discharged from Community Base Residential Level III within thirty (30) days of the referral.</li></ol>
<b>Clinical Exclusions</b>	Youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior. Once stable, youth who otherwise meet the eligibility criteria may be referred into the program.

### Staffing Requirements:

In addition to the staffing requirements listed in the general standards, these staff requirements must also be followed. If the standards referenced here differ from those in the general standards, these staffing requirements will supersede the general standards.

1. A ratio of one (1) staff to four (4) youth is maintained at all times.
2. At a minimum, two (2) childcare staff shall be on duty per living unit. Staff are always in attendance whenever youth are present.
3. Program staff must be supervised by a QMHP or a QMHP supervised MHP. Staff may include: paraprofessionals, resident counselors, teachers, teacher aides and classroom aides.
4. Additional personnel are available and called to duty in emergencies or are scheduled to meet any special needs during busy or more stressful periods such as for one-to-one (1:1) watches, new admissions, staff escort to emergency units, etc.
5. Youth that are ill or otherwise unable to attend school must be supervised by an available staff wherever the youth is located.
6. Staffing schedules shall reflect overlap in shift hours to accommodate the exchange of information for continuity of the youths' treatment, adequate numbers of staff reflective of the tone of the unit, appropriate staff gender mix, and the consistent presence and availability of a professional staff.
7. The teacher will have the assistance of at least one (1) behavioral support staff at all times in each classroom to provide necessary therapeutic redirection and interventions. In the event that staff needs to leave an educational activity for any length of time, the program provides additional staff to keep the ratio one to four (1:4).
8. The program must adhere to all applicable facility licensing requirements/regulations.

9. The program licensed staff psychiatrist or consultant provides psychiatric services at intervals of at least one (1) face-to-face visit per month. The psychiatrist is available for medical emergencies, assessments, and consults. The psychiatrist is on site for those emergencies that merit face-to-face services within one (1) hour of the call for assistance, and makes direct arrangements with a community hospital in the event that a youth is in need of possible hospitalization. This will be duly documented and kept on file at the program. There is an established protocol for appropriate qualified medical coverage in the absence of the designated psychiatrist. The psychiatrist has current courtesy or staff privileges at the community hospital within the same county as the program.
10. The licensed psychiatrist or licensed psychologist must be knowledgeable in evidence-based treatment and is responsible for the treatment program and for those in care, and provides on-call coverage twenty-four (24) hours per day/seven (7) days a week.
11. A licensed registered nurse is on staff to establish the system of operations for administering or supervising residents' medications, and medical needs or requirements, monitoring the residents' responses to medications, tracking and attending to dental and medical needs, and training direct care staff to administer medications and proper protocols.
12. Depending on the needs of the youth, the services of qualified professional and specialists in medicine, education, disabilities, speech, occupational and physical therapy, recreation and dietetics are available to the organization (either staff or contract).

### **Clinical Operations**

In addition to the clinical operation requirements listed in the general standards, these requirements must also be followed. If the standards referenced here differ from those in the general standards, these clinical operation requirements will supersede the general standards.

1. Services are available twenty-four (24) hours a day, seven (7) days a week.
2. The program will not exceed eight (8) youths per unit.
3. Program has an intake process that includes integration of information available on youth/family in the treatment planning to ensure appropriate and effective treatment. Program also has an established protocol for orienting youth to the program.
4. Provider is to follow all applicable professional practice standards and ethical guidelines.
5. The program actively engages the youth in planned, structured, therapeutic activities rooted in evidence-based treatment throughout the day, seven (7) days a week. There is a predictable and orderly routine that allows the youth to develop and enhance interpersonal skills and pro-social behaviors.
6. The physical setting is home-like and furnished appropriate to the youths' developmental age. The youth are encouraged to appropriately decorate and maintain their personal space.
7. Families are actively involved and participate in program events, therapy sessions, treatment team meetings, etc. They are engaged in opportunities to gain knowledge and practice of what works in the program that can be transferred to the home and community environment.
8. Educational services are provided within the program and are guided by the youths' IEP, as appropriate. The program works with the DOE to insure adherence to the youths' IEP and appropriateness of the educational services being provided. The credits earned while in treatment will be accepted by the receiving school and counted towards school credits. The program also works closely with the DOE to insure a smooth transition back to the home school or alternative transition plans for those who are not returning to their home schools.
9. The Program has clear procedures that specify its approach to positive behavior management. These procedures must clearly delineate its methods for training and implementation for positive behavioral interventions.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

10. The Contractor has established procedures/protocols in place for managing crises effectively and efficiently through the direct interventions of its professional clinical and medical staff. Included in these procedures are descriptions of methods for handling emergency and crisis situations and triaging youth who require more intensive interventions. Request for police assistance or crisis hotline assistance are limited to situations of imminent risk of harm to self or others.
11. The Contractor must do a Summary Annual Assessment for SEBD eligible youth in their care at the time the annual assessment is due on youth who have received at least three (3) months of services from the Contractor. See Summary Annual Assessment performance standards in Section II, Part D.
12. Five (5) therapeutic passes are allowed per episode of care for each youth in the program to assist him/her in meeting the MHTP goals as defined in the general standards.
13. Up to seven (7) bed hold days may be used to reserve the bed for a youth who is absent from the program as defined in the general standards.
14. Please see Section I General Standards for additional clinical operation requirements:
  - D. CAMHD Co-Occurring Disorders;
  - F. Referral Process for Services:
    - Out of Home Referrals;
    - Waitlist;
    - Access to services;
  - G. CAMHD Continuity of Care;
  - H. Staffing:
    - Orientation and Training and Training Requirements for CAMHD Contactors;
  - I. Supervision;
  - J. Evaluation of Staff Performance;
  - K. Credentialing Requirements;
  - L. Medication Monitoring / Tracking;
  - N. Service Quality;
  - O. Minimum Reporting Requirements;
  - P. Risk Management:
    - Criminal, Child Abuse, and Background Screening;
    - Safety;
    - Restraints and Seclusion;
    - Sentinel Events and Incidents;
    - Police;
  - V. Bed Hold and Therapeutic Passes:
    - Bed hold;
    - Therapeutic Pass.

### Documentation

In addition to the documentation requirements listed in the general standards, these requirements must also be followed. If the standards referenced here differ from those in the general standards, these documentation requirements will supersede the general standards.

1. Please see Section I General Standards for additional documentation requirements:
  - E. Service Planning:
    - Mental Health Treatment Plan including transition, crisis and discharge planning;
    - Discharge Summary;
  - M. Maintenance of Service Records:
    - Progress Notes;

- O. Minimum Reporting Requirements:
  - Monthly Treatment and Progress Summary;
  - CAMHD Attendance and Encounter Records.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### P. COMMUNITY-BASED RESIDENTIAL – LEVEL II

<b>Definition</b>	<p>Provide twenty-four (24) hour care and integrated evidence-based services that address the behavioral and emotional problems related to sexual offending, aggression or deviance that prevent the youth from taking part in family and/or community life. These programs are designed for those youth whose need can best be met in a structured program of small group living that includes educational, recreational, and occupational services.</p> <p>Community-Based Residential programs Level II provide support and assistance to the youth and the family to: 1) promote healthy sexual values and behaviors; 2) reduce and control deviant sexual arousal patterns; 3) help youth to develop victim empathy and appreciate feelings of others; 4) help youth accept full responsibility and be accountable for sexually abusive or antisocial behavior; 5) identify and change cognitive distortions or thinking errors that support or trigger offending; 6) develop and integrate relapse prevention strategies; 7) identify family dysfunction, issues, or problems that act to support minimization, denial, disruption of treatment, or trigger re-offending and; 8) provide management of other behavioral or emotional problems including trauma resulting from prior physical, sexual, and/or emotional abuse.</p>
<b>Services Offered</b>	<ol style="list-style-type: none"> <li>1. Evidence-based treatment interventions and a supportive therapy milieu for this target population.</li> <li>2. Opportunities for the youth to engage in age-appropriate structured and recreational activities.</li> <li>3. Psychotherapies and other treatments that address youth in the target population defined above.</li> <li>4. Individual Therapy at least one (1) time per week to address identified issues*.</li> <li>5. Group Therapy at least one (1) time per week unless to address identified issues, clinically contraindicated*.</li> <li>6. Family Therapy at least two (2) times per month as indicated in youth's plan*.</li> <li>7. Medication administration and monitoring.</li> <li>8. On-site educational program that addresses the educational goals and objectives identified in the youth's IEP as applicable.</li> <li>9. Substance abuse treatment and education as indicated in the youth's plan.</li> <li>10. Structured pre-vocational and vocational training activities as applicable.</li> </ol>
<b>Admission Criteria</b>	<p><u>All</u> of the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. The identified youth meets at least one (1) of the Service Eligibility criteria for CAMHD (as described in General Standards, Section A, Access &amp; Availability);</li> <li>2. The youth is registered with a Branch, and has an assigned MHCC;</li> </ol>

\* See performance standard for service referenced.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<ol style="list-style-type: none"> <li>3. The youth must be a male between the ages of twelve (12) and eighteen (18);</li> <li>4. Youth has severe emotional and/or behavioral disorder(s), which include sexually aggressive and/or deviant behavior;</li> <li>5. The youth has been identified as needing specialized treatment and the CSP identifies this service and measurable objectives for outcomes of this service prior to admission;</li> <li>6. An adequate trial of active treatment at a less restrictive level has been unsuccessful or given serious consideration and found to be inappropriate; and</li> <li>7. There is a reasonable expectation that the youth can benefit from this service within five (5) months.</li> </ol>
<b>Initial Authorizations</b>	<p>Authorization may be up to thirty-one (31) units per month for a maximum of two (2) months by the MHCC.</p> <p>Unit = one (1) day</p>
<b>Re-Authorization</b>	<p>Re-authorization may be up to an additional thirty-one (31) units monthly for a maximum of three (3) months with approval from the MHS1.</p> <p>Maximum stay of five (5) months.</p> <p>Unit = one (1) day</p> <p>Any request for re-authorization beyond five (5) months must be approved by the Clinical Director.</p>
<b>Continuing Stay Criteria</b>	<p><u>All</u> of the following criteria are met as determined by treatment team review:</p> <ol style="list-style-type: none"> <li>1. All admission criteria continue to be met;</li> <li>2. Services/items are being provided as indicated in the CSP and MHTP and there are regular and timely assessments and documentation of youth/family response to services. Timely and appropriate modifications are made to services and plan as needed;</li> <li>3. The youth continues to have specific needs that indicate that this is the most appropriate means of addressing those needs;</li> <li>4. The youth's primary behavioral health issues continue to present a risk or danger to themselves or others;</li> <li>5. The youth's measurable treatment goals have not been met; and</li> <li>6. There is a reasonable expectation that the youth will continue to make progress toward achieving his/her defined measurable treatment goals and objectives as identified in the youth's MHTP and CSP within the next month.</li> </ol>
<b>Discharge Criteria</b>	<p><u>One</u> (1) of the following criteria must be met:</p> <ol style="list-style-type: none"> <li>1. The youth is no longer eligible for CAMHD services. As part of discharge, the MHCC will help coordinate transfer to appropriate treatment services in the least disruptive</li> </ol>

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

	<p>manner possible;</p> <ol style="list-style-type: none"><li>2. The youth/family no longer wants to participate in this service and revokes consent with no imminent danger to others;</li><li>3. Youth has demonstrated minimal or no progress toward treatment goals for a two (2) month period and appropriate modifications of the MHTP have been made and implemented with no significant success and the CSP team determines that the youth is not benefiting from this services at this time;</li><li>4. Youth exhibits new symptoms and/or maladaptive behaviors which cannot be safely and effectively address through this service;</li><li>5. Targeted symptoms and/or maladaptive behaviors have abated to a level of severity which no longer requires this level of care as documented by attainment of goals the MHTP and CSP;</li><li>6. The youth's measurable treatment goals have been met;</li><li>7. There is a decrease in the identified sexually aggressive and/or deviant behavior and transition to a lower level of service to continue treatment is warranted; and</li><li>8. The youth has the knowledge and supports necessary to sustain treatment outcomes and/or to support a successful transition to a permanent placement or lower level of care.</li></ol>
<b>Service Exclusions</b>	<ol style="list-style-type: none"><li>1. Not offered at the same time as any out-of-home services.</li><li>2. Not offered at the same time as any Intensive In-Home Intervention, Multisystemic, Function Family Therapy or Intensive Outpatient service, except in cases where the youth has a planned discharge from Community-based Residential Level II within thirty (30) days of referral.</li></ol>
<b>Clinical Exclusions</b>	Youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior. Once stable, youth who otherwise meet the eligibility criteria may be referred into the program.

### Staffing Requirements:

In addition to the staffing requirements listed in the general standards, these staff requirements must also be followed. If the standards referenced here differ from those in the general standards, these staffing requirements will supersede the general standards.

1. Program must have documentation that staff providing services is trained and experienced in treatment of youth with sexually aggressive and/or deviant behavior.
2. At minimum, two (2) childcare staff shall be on duty per shift per living unit. Staff are always in attendance whenever youth are present.
3. A QMHP experienced in evidence-based treatment supervises the treatment program and the residential staff.
4. Additional personnel are available and called to duty in emergencies or are scheduled to meet any special needs during busy or more stressful periods such as for one-to-one (1:1) watches, new admissions, staff escort to emergency units, etc.



---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

5. Youth that are ill or otherwise unable to attend school must be supervised by an available staff wherever the youth is located.
6. Program staff must be supervised by a licensed QMHP knowledgeable of evidence-based treatment. Staff may include: childcare workers, resident counselors and teachers, and teaching aides.
7. Staffing schedules shall reflect overlap in shift hours to accommodate the exchange of information for the continuity of the youths' treatment, adequate numbers of staff reflective of the tone of the unit, appropriate staff gender mix, and the consistent presence and availability of a professional staff for role modeling.
8. The teacher will have the assistance of at least one (1) behavioral support staff at all times in each classroom to provide necessary therapeutic redirection and interventions. In the event that staff needs to leave an educational activity for any length of time, the program provides additional staff to keep the staff to student ratio at least one-to-four (1:4).
9. The program must adhere to all applicable facility licensing requirements/regulations.
10. The program staff psychiatrist or consultant provides psychiatric services at intervals of at least one (1) face-to-face visit a week. The psychiatrist is available for medical emergencies, assessments, and consults. The psychiatrist is on-site for those emergencies that merit face-to-face services within one (1) hour of the call for assistance, and makes direct arrangements with a community hospital in the event a youth is in need of possible hospitalization. This will be duly documented and kept on file at the program. There is an established protocol for appropriate, qualified medical coverage in the absence of the designated psychiatrist. The psychiatrist has current courtesy or staff privileges at the community hospital within the same county as the program.
11. Depending on the needs of the youth, the services of qualified professionals and specialists in medicine, education, recreation, dietetics, etc., are available among the organization's personnel or through cooperative arrangements.
12. The licensed psychiatrist or psychologist is responsible for the treatment program and for those in care, and provides on-call coverage twenty-four (24) hours per day, seven (7) days a week.
13. A licensed registered nurse is on staff or contracted to establish the system of operations for administering or supervising residents' medications, and medical needs or requirements, monitoring the residents' responses to medications, tracking and attending to dental and medical needs, and training direct care staff to medications and proper protocols.

### **Clinical Operations**

In addition to the clinical operation requirements listed in the general standards, these requirements must also be followed. If the standards referenced here differ from those in the general standards, these clinical operation requirements will supersede the general standards.

1. Services are available twenty-four (24) hours a day, seven (7) days a week.
2. The program is cognizant of community safety and risk issues and has policies, procedures, and the mechanisms to effectively manage these issues.
3. The program will not exceed eight (8) youth.
4. Program has an intake process that includes integration of information available on youth/family in the treatment planning to ensure appropriate and effective treatment. Program also has an established protocol for orienting youth to the program.
5. Provider is to follow all applicable professional practice standards and ethical guidelines.
6. The program is physically secure at all times. Twenty-four (24) hour supervision is provided to the youth. Behavioral/treatment plans are closely adhered to with consistency among the staff throughout the programming.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

7. Staff providing treatment must be a licensed QMHP or QMHP-supervised MHP experienced in evidence-based treatment for sexually offending youth with mental health needs and have a minimum of three (3) years direct experience in children's mental health and in this area.
8. Program has the ability to conduct a risk assessment with respect to offending behavior as part of ongoing treatment and assessment. Risk assessments should inform the planning process regarding when, where and how an individual can or should be transitioned to a less intensive level of treatment, rather than relying on completion of all program components as sole criteria.
9. The program actively engages youth in planned, structured, therapeutic activities throughout the day, seven (7) days a week. There is a predictable and orderly routine that allows youth to develop and enhance interpersonal skills and behaviors.
10. The physical setting is home-like and furnished appropriate to the youths' developmental age. The youth are encouraged to appropriately decorate and maintain their personal space.
11. Families are actively involved and participate in team meetings, program events, therapy sessions, and other activities. They are engaged in opportunities to gain knowledge and practice of what works in the program that can be transferred to the home and community environment.
12. Educational services are provided within the program and are guided by the youth's IEP as applicable. The program works with the DOE to insure appropriateness of the educational services and the credits earned while in treatment will be accepted by the receiving school and counted towards school credits. The program works closely with the DOE to insure adherence to the youth's IEP and a smooth transition back to the home school or alternative transition plans for those who are not returning to their home schools.
13. The Contractor must do a Summary Annual Assessment for SEBD eligible youth in their care at the time the annual assessment is due on youth who have received at least three (3) months of services from the Contractor. See Summary Annual Assessment performance standards in Section II, Part D.
14. Five (5) therapeutic passes as defined in the general standards are allowed per episode of care for each youth in the program to assist him/her in meeting the MHTP goals.
15. Up to seven (7) bed hold days may be used to reserve the bed for a youth who is absent from the program as defined in the general standards.
16. Please see Section I General Standards for additional clinical operation requirements:
  - D. CAMHD Co-Occurring Disorders;
  - F. Referral Process for Services:
    - Referral Acceptance;
  - G. CAMHD Continuity of Care;
  - H. Staffing;
  - I. Supervision;
  - J. Evaluation of Staff Performance;
  - K. Credentialing Requirements;
  - L. Medication Monitoring / Tracking;
  - N. Service Quality;
  - O. Minimum Reporting Requirements;
  - P. Risk Management:
    - Criminal, Child Abuse, and Background Screening;
    - Safety;
    - Restraints and Seclusion;
    - Sentinel Events and Incidents;
    - Police;
  - V. Bed Hold and Therapeutic Passes:
    - Bed hold;
    - Therapeutic Pass.

### Documentation

In addition to the documentation requirements listed in the general standards, these requirements must also be followed. If the standards referenced here differ from those in the general standards, these documentation requirements will supersede the general standards.

1. Please see Section I General Standards for additional documentation requirements:
  - E. Service Planning:
    - Mental Health Treatment Plan including transition, crisis and discharge planning;
    - Discharge Summary;
  - M. Maintenance of Service Records:
    - Progress Notes;
  - O. Minimum Reporting Requirements:
    - Monthly Treatment and Progress Summary;
    - CAMHD Attendance and Encounter Records.
2. The written risk assessment using empirically supported risk assessment instruments is advised and may include collateral information such as:
  - The victim's statement;
  - Reports from the victim's therapist, when available;
  - Juvenile justice records;
  - Psychiatric records;
  - Information from previous placements; and
  - School reports.

In addition, the assessor conducts a clinical interview. If available, the family is interviewed for information pertinent to decision making. The results of risk assessment instruments are not the sole criteria for decision-making.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### Q. COMMUNITY-BASED RESIDENTIAL – LEVEL I

<b>Definition</b>	<p>Provide twenty-four (24) hour locked care and integrated evidence-based services that address the behavioral and emotional problems related to sexually aggressive or deviant offending, that prevent the youth from taking part in family and/or community life. These programs are designed for those youth whose need can best be met in a structured program of small group living that includes educational, recreational, and occupational services.</p> <p>High Risk Community-based Residential program Level I provide support and assistance to the youth and the family to: 1) promote healthy sexual values and behaviors; 2) reduce and control deviant sexual arousal patterns; 3) help youth to develop victim empathy and appreciate feelings of others; 4) help youth display responsible and accountable behavior for sexually abusive or antisocial behavior with minimizing risk of reoffending and externalizing blame; 5) identify and change cognitive distortions or thinking errors that support or trigger offending ; 6) develop and integrate relapse prevention strategies; 7) identify family dysfunction, issues, or problems that act to support minimization, denial, disruption of treatment, or trigger reoffending and; 8) provide management of other behavioral or emotional problems.</p>
<b>Services Offered</b>	<ol style="list-style-type: none"> <li>1. Evidence-based treatment interventions and a supportive milieu therapy.</li> <li>2. Opportunities for the youth to engage in age-appropriate structured and recreational activities.</li> <li>3. Psychotherapies and other treatments that address youth in the target population defined above.</li> <li>4. Individual Therapy at least one (1) time per week to address identified issues*.</li> <li>5. Group Therapy at least one (1) time per week to address identified issues, unless clinically contraindicated*.</li> <li>6. Family Therapy at least two (2) times per month as indicated in youth's plan*.</li> <li>7. Medication management.</li> <li>8. On-site educational program that address the educational goals and objectives identified in the youth's IEP as applicable.</li> <li>9. Integrated individualized substance abuse counseling / education as indicated in youth's plan.</li> <li>10. Structured pre-vocational and vocational training activities as applicable.</li> </ol>
<b>Admission Criteria</b>	<p><u>All</u> of the following criteria must be met:</p> <ol style="list-style-type: none"> <li>1. The identified youth meets at least one of the Service Eligibility criteria for CAMHD (as described in General Standards, Section A, Access &amp; Availability);</li> <li>2. The youth is registered with a Branch and has an assigned MHCC;</li> </ol>

\* See performance standard for service referenced.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<ol style="list-style-type: none"> <li>3. The youth is a male between the ages of 12-18 years with severe emotional or behavioral disorders, who has been adjudicated for sexual offending;</li> <li>4. The youth has been identified as needing specialized treatment and presents a risk to others;</li> <li>5. An adequate trial of active treatment at a less restrictive level has been unsuccessful or given serious consideration but was found to be an inappropriate placement;</li> <li>6. There is a reasonable expectation that the youth can benefit from this services within five (5) months; and</li> <li>7. The CSP identifies this service and measurable objectives for outcomes of this service prior to admission.</li> </ol>
<b>Initial Authorizations</b>	<p>Authorization may be up to thirty-one units per month for a maximum of two (2) months by the MHCC.</p> <p>Unit = one (1) day</p>
<b>Re-Authorization</b>	<p>Re-authorization may be up to an additional thirty-one (31) units monthly for three (3) months with approval from the MHS1.</p> <p>Maximum stay of five (5) months.</p> <p>Unit = one (1) day</p> <p>Any request for re-authorization beyond five (5) months must be approved by the Clinical Director.</p>
<b>Continuing Stay Criteria</b>	<p><u>All</u> of the following criteria are met as determined by treatment team review:</p> <ol style="list-style-type: none"> <li>1. All admission criteria continue to be met;</li> <li>2. Services/items are being provided as indicated in the CSP and MHTP and there are regular and timely assessments and documentation of youth/family response to services. Timely and appropriate modifications are made to services and plans as needed;</li> <li>3. The youth continues to have specific needs that indicate that this is the most appropriate means of addressing those needs;</li> <li>4. The youth's primary behavioral health issues continue to present a risk or danger to others;</li> <li>5. The youth's measurable treatment goals have not been met; and</li> <li>6. There is a reasonable expectation that the youth can continue to make progress toward achieving his/her defined measurable treatment goals and objectives as identified in the youth's MHTP/CSP within the next month.</li> </ol>
<b>Discharge Criteria</b>	<p><u>One</u> (1) of the following criteria must be met:</p> <ol style="list-style-type: none"> <li>1. The youth is no longer eligible for CAMHD services. As part of discharge, the MHCC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible;</li> </ol>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<ol style="list-style-type: none"><li>2. The youth/family no longer wants to participate in this service and revokes consent with no imminent danger to others and no court order for treatment;</li><li>3. Youth has demonstrated minimal or no progress toward treatment goals for a two (2) month period and appropriate modifications of MHTP has been made and implemented with no significant success and the CSP team determines that the youth is not benefiting from this service at this time;</li><li>4. Youth exhibits new symptoms and/or maladaptive behaviors which cannot be safely and effectively addressed through this service;</li><li>5. Targeted symptoms and/or maladaptive behaviors have abated to a level of severity which no longer requires this level of care as documented by attainment of goals in the MHTP and CSP;</li><li>6. The youth's measurable treatment goals have been met;</li><li>7. There is a decrease in the identified sexually aggressive and/or deviant behavior and transition to a lower level of service to continue treatment is warranted; and</li><li>8. The youth has the knowledge and supports necessary to sustain treatment outcomes and/or to support a successful transition to a permanent placement or lower level of care.</li></ol>
<b>Service Exclusions</b>	<ol style="list-style-type: none"><li>1. Not offered at the same time as any out-of-home services.</li><li>2. Not offered at the same time as Intensive In-Home Intervention, Multisystemic Therapy, Functional Family Therapy, Intensive Outpatient programs, or Partial Hospitalization, except where the youth will be transitioned out and into the identified service within thirty (30) days of the referral.</li></ol>
<b>Clinical Exclusions</b>	Youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior. Once stable, youth who otherwise meet the eligibility criteria may be referred into the program.

### Staffing Requirements:

In addition to the staffing requirements listed in the general standards, these staff requirements must also be followed. If the standards referenced here differ from those in the general standards, these staffing requirements will supersede the general standards.

1. Program must have documentation that staff providing services is trained and experienced in treatment of youth with sexually aggressive or deviant offending behavior.
2. At a minimum, two (2) childcare staff shall be on duty per shift per living unit. Staff are always in attendance whenever youth are present.
3. A QMHP experienced in evidence-based treatment supervises treatment program and the residential staff.
4. Additional personnel are available and called to duty in emergencies or are scheduled to meet any special needs during busy or more stressful periods such as for one-to-one (1:1) watches, new admissions, staff escort to emergency units, etc.

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

5. Youth that are ill or otherwise unable to attend school must be supervised by an available staff wherever the youth is located.
6. Community-Based Residential Programs staff must be supervised by a licensed QMHP knowledgeable of evidence-based treatment. Staff may include: childcare workers, resident counselors and teachers, and teaching aides.
7. Staffing schedules shall reflect overlap in shift hours to accommodate the exchange of information for the continuity of the youths' treatment, adequate numbers of staff reflective of the tone of the unit, appropriate staff gender mix, and the consistent presence and availability of a professional staff for role modeling.
8. The teacher will have the assistance of at least one behavioral support staff at all times in each classroom to provide necessary therapeutic redirection and interventions. In the event that staff needs to leave an educational activity for any length of time, the program provides additional staff to keep the staff to student ratio at least one-to-four (1:4).
9. The program must adhere to all applicable facility licensing requirements/regulations.
10. The program staff psychiatrist or consultant provides psychiatric services at intervals of at least one (1) face-to-face visit a week. The psychiatrist is available for medical emergencies, assessments, and consults. The psychiatrist is on-site for those emergencies that merit face-to-face services within one (1) hour of the call for assistance, and makes direct arrangements with a community hospital in the event a youth is in need of possible hospitalization. This will be duly documented and kept on file at the program. There is an established protocol for appropriate qualified medical coverage in the absence of the designated psychiatrist. The psychiatrist has current courtesy or staff privileges at the community hospital within the same county as the program.
11. Depending on the needs of the youth, the services of qualified professionals and specialists in medicine, education, recreation, dietetics, etc., are available among the organization's personnel or through cooperative arrangements.
12. The licensed psychiatrist or psychologist is responsible for the treatment program and for those in care, and provides on-call coverage twenty-four (24) hours per day, seven (7) days a week.
13. A licensed registered nurse is on staff or contracted to establish the system of operations for administering or supervising residents' medications, and medical needs or requirements, monitoring the residents' responses to medications, tracking and attending to dental and medical needs, and training direct care staff to medications and proper protocols.

### **Clinical Operations**

In addition to the clinical operation requirements listed in the general standards, these requirements must also be followed. If the standards referenced here differ from those in the general standards, these clinical operation requirements will supersede the general standards.

1. Services are available twenty-four (24) hours a day, seven (7) days a week.
2. Services must be provided in a secure, locked facility.
3. The program is cognizant of community safety and risk issues and has policies, procedures, and the mechanisms to effectively manage these issues.
4. Program staff must be supervised by a licensed QMHP knowledgeable of evidence-based treatment. Staff include: therapist, teachers, resident counselors and teaching aides.
5. The program is physically secure at all times. Twenty-four (24) hour supervision is provided to the youth. Behavioral/treatment plans are closely adhered to with consistency among the staff throughout the programming.
6. Staff providing treatment must be a licensed QMHP experienced in evidence-based treatment for sexually offending youth with mental health needs and have a minimum of three (3) years direct experience in children's mental health and in this area.

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

7. Program has the capability to conduct a risk assessment with respect to offending behavior as part of ongoing treatment and assessment. Risk assessments should inform the planning process regarding when, where, and how an individual can or should be transitioned to a less intensive level of treatment, rather than rely on completion of all program components as sole criteria for discharge.
8. Program has an intake process that includes integration of information available on youth/family in the treatment planning to ensure appropriate and effective treatment. Program also has an established protocol for orienting youth to the program.
9. Provider is to follow all applicable professional practice standards and ethical guidelines.
10. The program actively engages youth in planned, structured, therapeutic activities throughout the day, seven (7) days a week. There is a predictable and orderly routine that allows youth to develop and enhance interpersonal skills and behaviors.
11. The physical setting is home-like and furnished appropriate to the youths' developmental age. The youth are encouraged to appropriately decorate and maintain their personal space.
12. Families are actively involved and participate in team meetings, program events, therapy sessions, and other activities. They are engaged in opportunities to gain knowledge and practice of what works in the program that can be transferred to the home and community environment.
13. Educational services are provided within the program and are guided by the youth's IEP as applicable. The program works with the DOE to insure appropriateness of the educational services and the credits earned while in treatment will be accepted by the receiving school and counted towards school credits. The program works closely with the DOE to insure adherence to the youth's IEP and a smooth transition back to the home school or alternative transition plans for those who are not returning to their home schools.
14. The Contractor must do a Summary Annual Mental Health Assessment for SEBD eligible youth in their care at the time the annual assessment is due on youth who have received at least three (3) months of services from the Contractor. See Annual Mental Health Assessment performance standards in Section II, Part D.
15. Five (5) therapeutic passes as defined in the general standards are allowed per episode of care for each youth in the program to assist him/her in meeting the MHTP goals.
16. Up to seven (7) bed hold days may be used to hold the bed of a youth who is absent from the program as defined in the general standards.
17. Please see Section I General Standards for additional clinical operation requirements:
  - D. CAMHD Co-Occurring Disorders;
  - F. Referral Process for Services:
    - Referral Acceptance;
  - G. CAMHD Continuity of Care;
  - H. Staffing;
  - I. Supervision;
  - J. Evaluation of Staff Performance;
  - K. Credentialing Requirements;
  - L. Medication Monitoring / Tracking;
  - N. Service Quality;
  - O. Minimum Reporting Requirements;
  - P. Risk Management:
    - Criminal, Child Abuse, and Background Screening;
    - Safety;
    - Restraints and Seclusion;
    - Sentinel Events and Incidents;
    - Police;
  - V. Bed Hold and Therapeutic Passes:



- Bed hold;
- Therapeutic Pass.

### Documentation

In addition to the documentation requirements listed in the general standards, these requirements must also be followed. If the standards referenced here differ from those in the general standards, these documentation requirements will supersede the general standards.

1. Please see Section I General Standards for additional documentation requirements:
  - E. Service Planning:
    - Mental Health Treatment Plan including transition, crisis and discharge planning;
    - Discharge Summary;
  - M. Maintenance of Service Records:
    - Progress Notes;
  - O. Minimum Reporting Requirements:
    - Monthly Treatment and Progress Summary;
    - CAMHD Attendance and Encounter Records.
2. The written risk assessment using empirically supported risk assessment instruments is advised and may include collateral information such as:
  - The victim's statement;
  - Reports from the victim's therapist, when available;
  - Juvenile justice records;
  - Psychiatric records;
  - Information from previous placements; and
  - School reports.

In addition, the assessor conducts a clinical interview. If available, the family is interviewed for information pertinent to decision making. The results of risk assessment instruments are not the sole criteria for decision-making.

Written risk assessment and evaluation include the youth's offense history and specific, detailed recommendations about the setting, intensity of intervention, and the level of supervision necessary for treatment.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### R. HOSPITAL-BASED RESIDENTIAL

<b>Definition</b>	Provide intensive in-patient treatment services to youth with severe emotional challenges who require short-term up to sixty (60) days hospitalization for the purposes of receiving intensive diagnostic, assessment and medication stabilization services. The highly structured program provides educational services, family therapy, and integrated service planning through a multi-disciplinary assessment of the youth, skilled milieu of services by trained staff who are supervised by a licensed professional on a twenty-four (24) hour per day basis. Services are provided in a locked unit of a licensed inpatient facility.
<b>Services Offered</b>	<ol style="list-style-type: none"> <li>1. Diagnostic and assessment services.</li> <li>2. Integrated service planning.</li> <li>3. Psychiatric services.</li> <li>4. Nursing Services.</li> <li>5. Medication management.</li> <li>6. Evidence-based treatment interventions and a supportive therapy milieu.</li> <li>7. Opportunities for the youth to engage in age-appropriate structured and recreational activities.</li> <li>8. Individual Therapy at least one (1) time per week to address identified issues*.</li> <li>9. Group Therapy at least one (1) time per week to address identified issues, unless clinically contraindicated*.</li> <li>10. Family Therapy at minimally two (2) times per month as indicated in the youth's plan*.</li> <li>11. On-site educational program that addresses the educational goals and objectives identified in the youth's IEP as applicable.</li> <li>12. Integrated individualized substance abuse assessment, counseling and education as indicated in the youth's plan.</li> <li>13. Evidence-based treatment interventions as suggested in the IEP and/or CSP.</li> <li>14. Program will be family centered, strengths-based and adhere to CASSP Principles.</li> <li>15. Intensive family/systems treatment focused on safely transitioning youth to a lesser level of care.</li> </ol>
<b>Admission Criteria</b>	<p><u>All</u> of the following criteria must be met:</p> <ol style="list-style-type: none"> <li>1. The identified youth meets at least one (1) of the Service Eligibility criteria for CAMHD (as described in General Standards, Section A, Access &amp; Availability);</li> <li>2. The youth is registered with a Branch and has an assigned MHCC;</li> <li>3. The youth must have primary behavioral health issues which require daily, intensive psychiatric treatment services to address risk factors such as suicidal and/or homicidal ideation or aggressive behavior;</li> </ol>

\* See performance standard for service referenced.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<ol style="list-style-type: none"> <li>4. The youth requires intensive, coordinated multi-disciplinary intervention within a locked therapeutic milieu;</li> <li>5. The youth's clinical and behavioral issues are unmanageable and unsafe to return home or to a temporary residence at night; and</li> <li>6. Reasonable expectation that the youth can improve sufficiently within fifteen (15) to sixty (60) days such that the youth can be treated in a less restrictive setting.</li> </ol>
<b>Initial Authorizations</b>	<p>Authorization may be up to fifteen (15) units with approval from the CAMHD Medical Director.</p> <p>Unit = one (1) day</p>
<b>Re-Authorization</b>	<p>Reauthorization may be up to fifteen (15) units with approval from the CAMHD Medical Director.</p> <p>Unit = one (1) day</p>
<b>Continuing Stay Criteria</b>	<p><u>All</u> of the following criteria are met as determined by treatment team review:</p> <ol style="list-style-type: none"> <li>1. All admission criteria continue to be met;</li> <li>2. Services/items are being provided as indicated in the CSP and MHTP and there are regular and timely assessments and documentation of youth/family response to services. Timely and appropriate modifications are made to services and plans as needed;</li> <li>3. The youth must have primary behavioral health issues which continue to require intensive, daily psychiatric treatment services to decrease risk factors such as suicidal and/or homicidal ideation or aggressive behavior;</li> <li>4. The youth's clinical and behavioral issues continue to be unmanageable and unsafe to treat in a less restrictive treatment setting; and</li> <li>5. There continues to be a reasonable expectation that the youth can improve sufficiently within fifteen (15) to forty-five (45) days such that the youth can be treated in a less restrictive setting.</li> </ol>
<b>Discharge Criteria</b>	<p><u>One</u> (1) of the following criteria must be met:</p> <ol style="list-style-type: none"> <li>1. The youth is no longer eligible for CAMHD services. As part of discharge, the MHCC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible;</li> <li>2. The youth's symptoms are stabilized sufficiently to permit movement to a less restrictive treatment setting;</li> <li>3. Medication is titrated so that there is no longer a need for daily psychiatric/nursing oversight;</li> <li>4. The youth no longer presents significant imminent risk of harm to self or others;</li> <li>5. The youth has strengthened skills, the family is involved and more confident that their child can be safely treated in a less</li> </ol>

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

	restrictive setting, and lessened need for restrictive interventions including readmission to in-patient programs; and 6. The youth is capable of participating in a less restrictive level of care.
<b>Service Exclusions</b>	1. Not offered at the same time as any out-of-home services. 2. Not offered at the same time as any Intensive In-Home Intervention, Multisystemic, Function Family Therapy or Intensive Outpatient service, except in cases where the youth has a planned discharge from Therapeutic Group Home within thirty (30) days of referral.
<b>Clinical Exclusions</b>	None

### Staffing Requirements:

In addition to the staffing requirements listed in the general standards, these staff requirements must also be followed. If the standards referenced here differ from those in the general standards, these staffing requirements will supersede the general standards.

1. The services must be provided by a multidisciplinary team knowledgeable in evidence-based treatment and comprised of the following with the stated ratios:
  - a. Child and adolescent board certified psychiatrist 1:16;
  - b. Licensed psychologist 1:16;
  - c. Intensive Family/Systems Therapist Credentialed LCSW, LMFT, or APRN with specialty training in family 1:12;
  - d. Rehabilitation Services Occupational Therapist (OT), Recreational Therapist (RT), and (Certified Substance Abuse Counselor (CSAC). Must include CSAC on staff 1:12;
  - e. Special Education certified teacher;
  - f. Nursing Staff:
    - 1<sup>st</sup> (day) shift 1:4;
    - 2<sup>nd</sup> (evening) shift 1:4;
    - 3<sup>rd</sup> (night) shift 1:6;
    - One (1) R.N. minimum on each shift; and
    - Minimum of two (2) nursing staff at all times.
2. Staff must be CAMHD credentialed as defined in the general standards.
3. Delegation Agreements will be sought for credentialing.
4. The program must be under the direction of a Hawaii licensed ABPN child and adolescent psychiatrist.
5. Psychiatric coverage is required and a psychiatrist must be a full time position on the unit.
6. The program staff ratios need to be adjusted during periods when acuity is high or there is greater activity.
7. CAMHD Medical Director will approve a one to one (1:1) staffing ratio when required.
8. Staffing ratios must apply to CAMHD HBR population and cannot be counted at the same time for staffing of acute or other populations.
9. All staff must have an understanding of and ability to assess symptoms, medication issues, and behaviors in order to be able to identify psychiatric situations requiring additional psychiatric or nursing staff assistance.

### Clinical Operations

In addition to the clinical operation requirements listed in the general standards, these requirements must also be followed. If the standards referenced here differ from those in the general standards, these clinical operation requirements will supersede the general standards.

1. This service must operate within a locked unit of a licensed accredited hospital.
2. Services must be available twenty-four (24) hours a day, seven (7) days a week.
3. Comprehensive multi-disciplinary assessments are performed within forty-eight (48) hours and include consideration of evidence-based treatment options, current DSM version assessments on Axes I – V, assessments of youth, family, community strengths/resources, and specific multi-modal treatment recommendations that target the specific bio-psycho-social factors that precipitated the admission and those that can be realistically targeted in treatment to maximize the opportunity for transition to a stable less restrictive level of care. The assessment also includes comprehensive evaluations of the youth's developmental milestones and course; family/systems and contextual influences current and past school, work, or other social role; ability to interact socially (including peer relationships); substance use/abuse; and a summary of all prior psychiatric hospitalizations, medication trials, and other mental health and /or psychosocial interventions including an assessment of their degree of success and/or failure.
4. A plan that emphasizes the youth's role in his family and community is required. This includes a normalized routine and an orderly schedule to help develop positive interpersonal skills and behaviors, more appropriate interactions with family and caregivers is to be developed within ten (10) days of admission based on observations and assessments.
5. Every admission must be documented.
6. The psychiatrist's participation in support of the youth must be documented at least once a week in treatment team meetings and in progress and treatment notes at least three (3) times per week and at least two (2) of these notes reflect face-to-face meetings with the youth. The psychiatrist observes, assesses and/or treats the youth in accordance with the treatment plan. The psychiatrist routinely assesses the effectiveness of treatment, coordination of treatment, management of medication, and medical treatment. A psychiatrist is available twenty-four (24) hours a day to direct any psychiatric emergencies and emergency interventions.
7. Involvement of parent(s)/caregiver(s) is/are essential in the provision of this service and is a necessary tool in enabling the youth to move to less restrictive services. This requirement, however, should not be allowed to become a barrier to the delivery of services to youth whose parent(s) or caregiver(s) is/are not able to participate or not available.
8. Transition planning for less intensive service options must begin at the onset of this service delivery and documentation must demonstrate this planning as well as activities undertaken to support this transition process. Any known service providers, who will be treating the youth and family after discharge, will be included in transition planning efforts.
9. The MHCC and Clinical Director will engage in ongoing collaboration with the HBR staff regarding the youth's status and adherence to the treatment plan. Specifically, the HBR staff must work collaboratively with the MHCC, Clinical Director, youth and family in the development of individualized treatment, discharge criteria and transition plans that are informed by current diagnostic and assessment information.
10. The HBR program has clear procedures for training, which specify its approach to positive behavior supports. These procedures must clearly delineate its methods of training and implementation for positive behavioral intervention.
11. For the Hospital Based Residential (HBR) level of care, a written admission summary that details the initial diagnosis, mental status, presenting problem, preliminary recommendations and further assessments/testing needed is submitted to the CAMHD Branch within five (5) working days of admission.
12. Please see Section I General Standards for additional clinical operation requirements:

- D. CAMHD Co-Occurring Disorders;
- F. Referral Process for Services:
  - Referral Acceptance;
- G. CAMHD Continuity of Care;
- H. Staffing;
- I. Supervision;
- J. Evaluation of Staff Performance;
- K. Credentialing Requirements;
- K. Medication Monitoring / Tracking;
- N. Service Quality;
- O. Minimum Reporting Requirements:
  - CAMHD Admission Summary;
- P. Risk Management:
  - Criminal, Child Abuse, and Background Screening;
  - Safety;
  - Restraints and Seclusion;
  - Sentinel Events and Incidents;
  - Police.

### Documentation

1. In addition to the documentation requirements listed in the general standards, these requirements must also be followed. If the standards referenced here differ from those in the general standards, these documentation requirements will supersede the general standards.
2. Please see Section I General Standards for documentation requirements including the following:
  - E. Service Planning:
    - Mental Health Treatment Plan including transition, crisis and discharge planning;
    - Discharge Summary;
  - M. Maintenance of Service Records:
    - Progress Notes;
  - O. Minimum Reporting Requirements:
    - Monthly Treatment and Progress Summary;
    - CAMHD Attendance and Encounter Records.
3. Daily attendance of each youth participating in the program must be documented showing number of hours in attendance for billing purposes.
4. An RN's progress note showing participation in support of the youth and treatment plan must be documented at least daily for the first week and in each subsequent three (3) day period. Every nursing contact, including medication administration, must be documented and placed in the youth's chart within twenty-four (24) hours of service.



***Section II: Part D:***

**Support for Emotional and Behavioral Development  
Performance Standard**



## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### A. PEER SUPPORT

<b>Definition</b>	Provided by peer counselors to youth, young adults and their families under the consultation, facilitation or supervision of a QMHP who understands rehabilitation and recovery. This service provides scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Youth and their families actively participate in decision-making and the operation of the programmatic supports.
<b>Services Offered</b>	<ol style="list-style-type: none"> <li>1. Self-help support groups.</li> <li>2. Telephone support lines.</li> <li>3. Drop in centers.</li> <li>4. Sharing the peer counselor's own life experiences related to mental illness will build alliances that enhance the consumers ability to function in the community.</li> <li>5. These services may occur at locations where consumers are known to gather (e.g., churches, parks, community center, etc.).</li> </ol>
<b>Admission Criteria</b>	<p><u>All</u> of the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. The identified young adult or youth meets SEBD Eligibility criteria for CAMHD (as defined in Appendix B-7), is registered with a Branch and has an assigned MHCC;</li> <li>2. The young adult or youth must be between the ages of twelve (12) to twenty-one (21);</li> <li>3. The young adult, youth and their family desires a peer counselor and is actively involved in determining activities and amount of time spent with peer counselor; and</li> <li>4. The CSP includes this service and measurable objectives for outcomes of this service prior to admission.</li> </ol>
<b>Initial Authorizations</b>	<p>Authorization may be up to sixty-four (64) units per month for three (3) months by the MHCC.</p> <p>Unit = fifteen (15) minutes</p>
<b>Re-Authorization</b>	<p>Reauthorization may be up to sixty-four (64) units a month for three (3) months as authorized by the MHS1, not to exceed (12) months.</p> <p>Unit = fifteen (15) minutes</p>
<b>Continuing Stay Criteria</b>	<p><u>All</u> of the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. The young adult, youth and family is able and/or willing to actively engage in this service as reflected on the CSP.</li> </ol>
<b>Discharge Criteria</b>	<p>Meets at least <u>one</u> (1) of the following:</p> <ol style="list-style-type: none"> <li>1. The young adult or youth is no longer eligible for SEBD services. As part of discharge, the MHCC will help coordinate</li> </ol>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	transfer to appropriate treatment services in the least disruptive manner possible; 2. The young adult, youth or family has increased functional skills to the point that peer support is longer needed; 3. Young adult, youth and/or family has been linked with natural supports that was previously provided by a peer counselor; 4. The young adult or youth/family no longer wants to participate in this service.
<b>Service Exclusions</b>	Peer Support is not a standalone service, but is part of a larger treatment plan.
<b>Clinical Exclusions</b>	Young adult or youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior. Once stable, young adult or youth who otherwise meet the eligibility criteria may be referred into this service;

### Staffing Requirements:

1. In addition to the staffing requirement listed in the general standards, these staff requirements must also be followed. If the standards referenced here differ from those in the general standards, these staffing requirements will supersede the general standards.
2. Peer counselor means the individual has self-identified as a consumer or family member of a recipient of mental health services; has received specialized training; has passed a test, which includes both written and oral components of the training; has passed a background check and is credentialed as a peer counselor.
3. Peer counselor must demonstrate:
  - a. That they are well grounded in their own recovery for at least one (1) year or a family member of some well grounded in his/her own recovery.
  - b. Willingness to a pretest for reading comprehension and language composition; and
  - c. Qualities of leadership, including governance, advocacy, creation, implementation or facilitation of peer-to-peer groups or activities.
4. Peer counselor must be able to:
  - a. Identify services and activities that promote recovery by instilling hope and which decrease stigma in the environments in which they serve;
  - b. Articulate points in their own recovery stories that are relevant to the obstacles faced by consumers and the family members of mental health services;
  - c. Promote personal responsibility for recovery as the individuals or family members of consumers of mental health services defines recovery;
  - d. Implement recovery practices in the broad arena of mental health services delivery system;
  - e. Provide a wide range of tasks to assist consumers in regaining control over their own lives and recovery process (e.g. promoting socialization, self advocacy, developing natural supports, stable living arrangements, education, supported employment);
  - f. Serve as a consumer advocate;
  - g. Provide consumer information and peer support in a range of settings; and
  - h. Model competency in recovery and ongoing coping skills.

### Clinical Operations

1. Program must have a QMHP that oversees all program staff and is responsible for all clinical decisions made.

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

2. Peer support services are provided by credentialed Peer Counselors under the consultation, facilitation or supervision of a QMHP who understands rehabilitation and recovery.
3. Peer counselor training shall be focused on the principles and concepts of recovery and how this differs from the medical model, the creation of self-help and coping skills and advocacy. Training will include:
  - a. Understanding the Hawaii's system of care including CAMHD;
  - b. What is peer support and how it promotes recovery;
  - c. How to advocate for age appropriate peer support projects;
  - d. How to facilitate groups and teams;
  - e. Understand self-directed recovery;
  - f. How to create your own self-help coping skills plan;
  - g. How to start and sustain self-help/mutual support groups;
  - h. How to form and sustain a personal support team;
  - i. How to promote recovery, self-determination and community reintegration;
  - j. Assist consumer to do for themselves and each other;
  - k. Assist in skill building, goal setting, and problem solving;
  - l. Assist consumers to build their own self-directed recovery tools; and
  - m. Assist consumers by supporting them in development of an individual service plan that has recovery goals and specific steps to attain each goal.
4. Peer counselors are responsible for the implementation of peer support services
5. The peer counselor should be assigned no more than four (4) young adult, youths or family member for mentoring or as identified in the peer counselor's supervision plan.
6. The program must have clear procedures, which specify its approach to young adult, youth or family member to peer counselor match, screening of young adult or youth, screening of peer counselor, supervision plans, training plans.
7. Peer counselors that are matched to mentor individuals must maintain monthly face-to-face contact at least two (2) times per month.
8. Peer counselor receive at a minimum, one (1) hour a month of client-specific group supervision and one (1) hour a month of individual supervision by a QMHP or a MHP under the supervision of a QMHP utilizing a combination of methods such as direct observation, coaching, and role modeling to improve the level of skill. Case reviews must be part of each supervision hour.
9. Peer counselor supervision is also expected to include the development of and evaluation of plans for staff development. In addition, peer counselors are expected to work under the guidance of a QMHP or MHP under the supervision of a QMHP.
10. Please see Section I General Standards for additional clinical operation requirements:
  - D. Co-Occurring Disorders;
  - F. Referral Process for Services:
    - Referral Acceptance;
  - G. CAMHD Continuity of Care;
  - H. Staffing;
  - J. Supervision;
  - J. Evaluation of Staff Performance;
  - K. Credentialing Requirements;
  - N. Service Quality;
  - O. Minimum Reporting Requirements;
  - P. Risk Management:
    - Criminal, Child Abuse, and Background Screening;
    - Safety;
    - Restraints and Seclusion;
    - Sentinel Events and Incidents;

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

- Police.

### Documentation

1. The peer counselor shall maintain contact/activity log for each encounter with begin/end times and activities during time together. These logs shall be fully dated and signed by the staff providing supervision, originals of which shall be maintained in the agency's master file within twenty-four (24) hours of service.
2. The Contractor must submit a written discharge summary on all young adult, youth or family member within *one (1) week* of service termination. The discharge summary shall include the duration of service, level(s) of care, young adult, youth or family member's adjustment, significant problems or concerns that arose, significant young adult, youth or family member's accomplishments, the transition process and status of the young adult, youth or family member in relation to ability to develop and maintain positive peer/social interactions.
3. Provider Monthly Summary: Contractors must submit monthly progress summary reports by the 5<sup>th</sup> working day of the following month specifying young adult, youth or family member served, setting of service, dates of service, targets addressed by the service and goodness of fit to the young adult, youth or family member.
4. Please see Section I General Standards for additional documentation requirements:
  - E. Service Planning:
    - Mental Health Treatment Plan including transition, crisis and discharge planning;
    - Discharge Summary;
  - M Maintenance of Service Records:
    - Progress Notes;
  - O Minimum Reporting Requirements:
    - Monthly Treatment and Progress Summary.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### B. COMPREHENSIVE MENTAL HEALTH ASSESSMENT

<b>Definition</b>	This assessment is performed (a) as part of the data collected to determine eligibility for youth/young adults referred for CAMHD services through the SEBD program, and/or (b) to provide needed comprehensive clinical information on youth/young adults in the SEBD program, to assist with coordination of services and with treatment planning. This strengths-based approach seeks to identify the needs of the youth or young adult in the context of their family and community. This service includes interviews, assessment activities, written report, and feedback to the young adult or youth and the parent(s) or guardian(s).
<b>Services Components</b>	<ol style="list-style-type: none"> <li>1. Complete the collection of assessment data (review documentation, interview family member/s, interview and test the young adult or youth, and obtain collateral information) within fifteen (15) working days of the referral and authorization;               <ol style="list-style-type: none"> <li>a. The assessment should incorporate significant information regarding presenting problems, family psychiatric history, medical history, psychosocial, educational, legal, and substance use status;</li> <li>b. Assessors are requested to utilize Structured Diagnostic Interviews such as the Diagnostic Interview Schedule for Children (DISC), Children's Interview for Psychiatric Syndromes (CHIPS), Schedule for Affective Disorders and Schizophrenia for School Aged Children (K-SADS), or Anxiety Disorders Interview Schedule Child/Parent Version (ADIS-IV);</li> <li>c. The family/guardians is interviewed;</li> <li>d. A face-to-face interview with the young adult or youth is required to obtain mental status information and collect information through testing and verbal exchange;</li> <li>e. Face-to-face or telephone interviews with relevant collaterals (e.g., teacher, therapist, Child Welfare worker) should be pursued; and</li> <li>f. The CAFAS/PECFAS<sup>4</sup> and CASII should be completed and included in the report. In general, the ASEBA checklists should be completed, including Parent, Teacher, and Youth self-report forms, with both raw data and computer-generated reports attached to the mental health assessment report<sup>5</sup>.</li> </ol> </li> <li>2. The assessor will:               <ol style="list-style-type: none"> <li>a. Review the findings in a face-to-face feedback session (where feasible) with young adult or youth/family, within five (5) working days of the report's completion, and document this in a progress notes. If, after extensive efforts are made (i.e. at least three (3) attempts), the</li> </ol> </li> </ol>

<sup>4</sup> The PECFAS is the appropriate instrument for children under the age of 6 years.

<sup>5</sup> There are times when the young adult or youth will refuse to complete the YSR checklist, or the parent or teacher is unavailable to complete their comparable versions of the checklist or does not return the data within the timeline.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p>provider is not able to schedule a face-to-face feedback session, a phone feedback session is the alternative. Inability to contact the family within the specified time will be reported to the MHCC who will document it in the progress notes; and</p> <p>b. Obtain written informed consent, or ensure that such consent has been obtained, before conducting evaluation.</p>
<b>Admission Criteria</b>	<p><u>All</u> of the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. The young adult or youth is enrolled with a Branch, and is in the process of eligibility determination for the SEBD program;</li> </ol> <p style="text-align: center;"><b>OR</b></p> <ol style="list-style-type: none"> <li>2. The identified young adult or youth meets SEBD Eligibility criteria for CAMHD (See Appendix B-7), is registered with a Branch and has an assigned MHCC;</li> </ol> <p style="text-align: center;"><b>AND</b></p> <ol style="list-style-type: none"> <li>3. The treatment team determines there is a need for comprehensive clinical information on the youth/young adult to inform coordination of services and treatment planning.</li> </ol>
<b>Initial Authorizations</b>	<p>Authorization may be up to twenty (20) units with approval of the Branch Chief.</p> <p>This includes up to sixteen (16) units for assessment activities and up to four (4) units for the feedback session.</p> <p>Note: There is no payment for travel time, wait time, no-shows or cancellations. These units do not include report-writing time, as it is incorporated in the unit cost.</p> <p>Unit = fifteen (15) minutes</p>
<b>Re-Authorizations</b>	<p>If under exceptional circumstances additional units are needed, the provider must submit justification for approval by the Branch Chief.</p>
<b>Discharge Criteria</b>	<p>At least <u>one</u> (1) of the following criteria is met:</p> <ol style="list-style-type: none"> <li>1. The assessment and feedback session are completed;</li> <li>2. The written report has been submitted to the Branch Chief and meets these standards for clinical content. Evaluations not meeting these standards will be returned to the evaluator with suggested changes/concerns identified;</li> <li>3. The young adult or youth/family no longer wants to participate in this service and revokes consent in writing<sup>3</sup>;</li> <li>4. The young adult or youth is no longer eligible for SEBD services. As part of discharge, the MHCC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible.</li> </ol>

<sup>3</sup> If the young adult or family revokes consent or refuses to release the report to CAMHD, they will be liable for the cost of the service.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

<b>Service Exclusions</b>	Comprehensive Mental Health Assessment will not be preformed for a young adult/youth who have already had an adequate mental health assessment within one (1) year. The assessment must be a written report that meets these quality standards as determined by the Branch Chief's review of the report.
<b>Clinical Exclusions</b>	Young adult or youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior. Once stable, young adult or youth who otherwise meet the eligibility criteria may be referred into this service;

### Staffing Requirements

1. The provider of a Comprehensive Mental Health Assessment shall meet one of the following requirements:
  - a. Credentialed by CAMHD as a Qualified Mental Health Professional (QMHP);  
**OR**
  - b. Credentialed by CAMHD as a Mental Health Professional (MHP);  
**AND**
  - c. Working under the supervision of a QMHP. The supervisor is expected to review all data on which the current report is based, and participate in the interpretation of data and the development of the diagnoses and recommendations. The supervisor is to co-sign the report acknowledging supervisory responsibility for the assessment.
2. Assessors are to follow all applicable professional practice standards and ethical guidelines.

### Clinical Operations

1. Direct service providers must coordinate with family/significant others and with other systems of care such as education, juvenile justice, child welfare as needed to provide service.
2. Direct service providers must obtain consents for assessments.
3. Report contains all components listed in the documentation section.
4. Report is typed.
5. Report is submitted to Branch Chief within twenty (20) working days of referral and authorization.

### Documentation

The complete written report is due within twenty (20) working days from date of referral and authorization. Written report includes all of the following:

1. Date(s) of assessment and date of report;
2. Identifying information: young adult or youth name, DOB, legal guardian, home school, grade level, IDEA status;
3. Reason for referral;
4. Sources of information: including review of records, interviews, and assessment tools;
5. Brief developmental, medical, family, social, educational, and psychiatric history. History should include past and current use of and reasons for psychotropic medications and reports of significant past traumatic experiences;
6. Substance use history;
7. Description and history of presenting problems;
8. Mental Status Exam;
9. Assessment results and interpretation; must include specific scores from psychometric instruments, plotted profiles when appropriate, and clear interpretations;
10. Description of young adult or youth and family strengths including formal and informal supports;

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

11. Clinical formulation/justification of the diagnosis;
12. Diagnostic impressions: DSM IV-5 axes;
13. Summary of findings highlighting strengths, concerns, and needs that must be met for young adult or youth to function adequately in their home and community;
14. Strength-based recommendations with suggested goals and measurable objectives must be included. Recommendations will conform to the following:
  - a. Supported by research evidence;
  - b. Described and address the needs of the young adult or youth and family;
  - c. Avoid specifying a particular services, program or eligibility status. For example, it should not be specified that young adult or youth needs “residential treatment.” Instead, recommendations should focus on youth/young adult’s particular needs, e.g. “the youth is in need of close supervision due to...”;
  - d. Include treatment interventions that are provided in the least restrictive manner that will address the needs of the young adult or youth and family. These may include therapeutic strategies or behavioral support approaches;
  - e. Report is signed by the assessor (and his/her supervisor when applicable) acknowledging responsibility for the assessment.



## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### C. FOCUSED MENTAL HEALTH ASSESSMENT

<b>Definition</b>	This assessment is performed any time the treatment team determines that an in-depth evaluation of the young adult/youth is necessary for satisfactory clinical care. This assessment is done to clarify diagnostic and treatment issues when new clinical symptoms have emerged or when there is a lack of expected progress. The assessment builds upon previous evaluations, incorporates additional relevant data (e.g., from interviews and the review of new information) and answers one or more specific referral questions. This service includes assessment activities, written report, and feedback to the young adult or the youth and his/her parent(s) or guardian(s).
<b>Services Components</b>	<ol style="list-style-type: none"><li>1. Complete the collection of assessment data (review documentation, interview family member(s), interview and test the young adult or youth, and obtain collateral information) within fifteen (15) working days of the referral and authorization;<ol style="list-style-type: none"><li>a. The family/guardians will be interviewed. Assessors are required to utilize structured diagnostic interviews [such as the Schedule for Affective Disorders and Schizophrenia for School-Aged Children (K-SADS) or Children's Interview for Psychiatric Syndromes (CHIPS)] or targeted self-report inventories as indicated to answer the referral question(s);</li><li>b. Behavioral observations across the youth/young adult's environments may be conducted if necessary to answer referral question;</li><li>c. A face-to-face interview with the young adult/youth is required to update mental status information and collect additional information through testing and verbal exchange;</li><li>d. Face-to-face or telephone interviews with relevant collaterals (e.g., teacher, therapist, Child Welfare worker) should be pursued;</li><li>e. The CAFAS/PECFAS<sup>4</sup> and the CASII should be completed and included in the report. The ASEBA checklists should be completed, including the Parent, Teacher and Young adult or youth Self-report forms, with both raw data and computer-generated reports attached to the mental health assessment report<sup>5</sup>; and</li><li>f. Qualified providers may administer selected, evidenced-base psychological test or self-report measures when needed to answer specific referral question(s) (see Section III for practice guidelines regarding assessment instruments for specific disorders).</li></ol></li></ol>

<sup>4</sup> The PECFAS is the appropriate instrument for children under the age of 6 years.

<sup>5</sup> There are times when the young adult or youth will refuse to complete the YSR checklist, or the parent or teacher is unavailable to complete their comparable versions of the checklist or does not return it within the timeline. This should be documented in the written report.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p>2. The assessor will:</p> <ol style="list-style-type: none"> <li>a. Complete the written report within twenty (20) working days from the referral and authorization;</li> <li>b. Review the findings in a face-to-face feedback session with young adult or youth/family, within five working days of the report's completion. If, after extensive efforts are made (i.e. at least three attempts), the provider is not able to schedule a face-to-face feedback session, a phone feedback session is the alternative. Inability to contact the family within the specified time will be reported to the MHCC who will document it in the progress notes; and</li> <li>c. Obtain written informed consent, or ensure that such consent has been obtained, before conducting evaluation or releasing the report to the appropriate person or agency.</li> </ol>
<b>Admission Criteria</b>	<p><u>All</u> of the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. The identified young adult or youth meets SEBD Eligibility criteria for CAMHD (See Appendix B-7), is registered with a Branch and has an assigned MHCC;</li> <li>2. Young adult or youth is in need of assessment services for at least one of the following reasons; <ol style="list-style-type: none"> <li>a. Requires a focused assessment to clarify diagnoses and/or treatment issues;</li> <li>b. Requires a focused assessment to address lack of treatment progress; and</li> <li>c. Requires a focused assessment to address persistent or new clinical symptoms.</li> </ol> </li> </ol>
<b>Initial Authorizations</b>	<p>Authorization may be up to sixteen (16) units with approval from Branch Chief.</p> <p>Authorization includes up to twelve (12) units of assessment activities and up to four (4) units for the face-to-face feedback session.</p> <p>Note: There is no payment for travel time, wait time, no-shows or cancellations. These units do not include report-writing time as it is incorporated in the unit cost.</p> <p>Unit = fifteen (15) minutes</p>
<b>Re- Authorization</b>	<p>If under exceptional circumstances additional units are needed for assessment activities, the provider must submit justification for approval by the Branch Chief.</p> <p>Justification must include an explanation of why the standard authorization was insufficient as well as the details of the specific evidence-based assessments to be utilized.</p>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

<b>Discharge Criteria</b>	At least <u>one</u> (1) of the following criteria is met: <ol style="list-style-type: none"><li>1. The assessment and feedback session have been completed; the written report has been submitted to the Branch Chief and meets these standards for clinical and operational content. Evaluations not meeting these standards will be returned to the evaluator with suggested changes/concerns identified;</li><li>2. The young adult or youth/family no longer wants to participate in this service and revokes consent<sup>6</sup>; or</li><li>3. The young adult or youth no longer eligible for SEBD services. As part of discharge, the MHCC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible.</li></ol>
<b>Service Exclusions</b>	<ol style="list-style-type: none"><li>1. A Focused Mental Health Assessment will not be performed with youth or young adults who have a Mental Health Assessment current within one (1) year for whom there is no current clinical question needing immediate further investigation.</li><li>2. A Focused Mental Health Assessment is not a stand-alone service, but is part of a larger treatment plan, and the young adult or youth/family must be actively engaged in the services.</li><li>3. When a youth or young adult is due for an annual assessment and there is no specific clinical question to be addressed, a Summary Annual Assessment should be performed.</li></ol>
<b>Clinical Exclusions</b>	Young adult or youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior. Once stable, young adult or youth who otherwise meet the eligibility criteria may be referred into this service.

### Staffing Requirements:

1. The provider of a Focused Mental Health Assessment must be a CAMHD credentialed QMHP meeting one (1) of the following requirements:
  - a. Credentialed by CAMHD as a Qualified Mental Health Professional (QMHP);  
**OR**
  - b. Credentialed by CAMHD as a Mental Health Professional (MHP);  
**AND**Working under the supervision of a QMHP. The supervisor is expected to review all data on which the current report is based, and participate in the interpretation of data and the development of the diagnosis and recommendations. The supervisor is to co-sign the report acknowledging supervisory responsibility for the assessment.

<sup>6</sup> If the young adult or family revokes consent or refuses to release the report to CAMHD, they will be liable for the cost of this service.

2. Assessors are to follow all applicable professional practice standards and ethical guidelines. Assessors are expected to provide only those services and utilize only those assessment instruments for which they have received adequate training. Most psychological testing must be performed only by a licensed psychologist or by a psychologist-in-training under the supervision of a licensed psychologist.

### **Clinical Operations**

1. Direct service providers must coordinate with family/significant others and with other systems of care such as education, juvenile justice system, child welfare as needed to provide service.
2. Direct service providers must obtain consents for assessments.
3. Report contains all content components listed in the documentation section.
4. Report is typed.
5. Report is submitted to MHCC within twenty (20) working days of referral and authorization.

### **Documentation**

Complete written report due within twenty (20) working days from date of referral and authorization.

Written report includes all of the following:

1. Date(s) of assessment and date of report;
2. Identifying information: young adult or youth name, DOB, legal guardian, home school, grade level, IDEA status;
3. Reason for referral. This must include the specific referral questions to be addressed;
4. Sources of information: including review of records, interviews, and assessment tools;
5. Brief developmental, medical, family, social, educational, and psychiatric history. History should include past and current use of and reasons for psychotropic medications and reports of significant past traumatic experiences. This section should highlight changes from past assessment reports and aspects of the history that are relevant to the referral question(s);
6. Substance use history;
7. Description and history of presenting problems;
8. Behavioral observations and Mental Status Exam;
9. Assessment results and interpretation; must include specific scores from psychometric instruments, plotted profiles when appropriate, and clear interpretations;
10. Description of young adult or youth and family strengths including formal and informal supports;
11. Clinical formulation/justification of the diagnosis;
12. Diagnostic impressions: DSM IV-5 axes;
13. Summary of the findings highlight strengths, concerns, and needs that must be met for young adult or youth to function adequately in their home and community. This summary should answer the referral question(s), including addressing the function of the current problematic behavior;
14. Strength-based recommendations with suggested goals and measurable objectives must be included. Recommendations will conform to the following:
  - a. Supported by research evidence;
  - b. Describe and address the needs of the young adult or youth and family and build upon strengths;
  - c. Avoid specifying a particular services, program or eligibility status. For example, it should not be specified that young adult or youth needs "residential treatment." Instead, recommendations should focus on young adult or youth's particular needs, e.g. "the young adult or youth is in need of close supervision due to...";
  - d. Include treatment interventions that are provided in the least restrictive manner that will address the needs of the young adult or youth and family. These may include therapeutic strategies or behavioral support approaches;

- e. The report is signed by the assessor (and his/her supervisor when applicable) acknowledging responsibility for the assessment.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### D. SUMMARY ANNUAL ASSESSMENTS

<b>Definition</b>	This assessment is performed in order to describe the current status of the young adult or youth and his or her circumstances. It is performed yearly, when the CSP team determines that there are no clinical concerns that would call for a focused or comprehensive assessment to be performed instead. The service includes a brief assessment and report, with feedback to the young adult or youth and his/her parent(s) or guardian(s). CAMHD contracted providers that are currently providing services and that have known the young adult or youth for at least three (3) months shall provide the Summary Annual Assessment when it is due or as defined in the specific service standard.
<b>Services Components</b>	<ol style="list-style-type: none"><li>1. Complete the collection of assessment data and the written report within fifteen (15) working days of the referral and authorization.</li><li>2. The CAFAS/PECFAS<sup>7</sup> and CASII should be completed and included in the report. The ASEBA checklists should be completed, including Parent, Teacher, and Young adult or youth self-report forms, with both raw data and computer-generated reports attached to the mental health assessment report<sup>8</sup>.</li><li>3. Assessment activities may include a record review and brief interviews the young adult, young adult or youth, family members or other collaterals as needed to complete the summary.</li><li>4. Review the findings in a face-to-face feedback session (where feasible) with the young adult or young adult or youth/family, within five working days of the report's completion, and document this in the progress notes. If, after extensive efforts are made (i.e. three attempts), the provider is not able to schedule a face-to-face feedback session, a phone feedback session is the alternative. Inability to contact the family within the specified time will be documented in the progress notes.</li><li>5. Obtain written informed consent, or ensure that such consent has been obtained, before conducting evaluation.</li></ol>
<b>Admission Criteria</b>	<p><u>All</u> of the following criteria are met:</p> <ol style="list-style-type: none"><li>1. The identified young adult or youth meets SEBD Eligibility criteria for CAMHD (See Appendix B-7), is registered with a Branch and has an assigned MHCC; and</li><li>2. Young adult or youth is in need of a Summary Annual Assessment as part of the comprehensive delivery of services.</li></ol>

<sup>7</sup> The PECFAS is the appropriate instrument for children under the age of 6 years.

<sup>8</sup> There are times when the young adult or youth will refuse to complete the YSR checklist, or the parent or teacher is unavailable to complete their comparable versions of the checklist or does not return the data within the timeline. This should be noted and discussed in the written evaluation report.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

<b>Initial Authorizations</b>	Authorization may be up to eight (8) units by the MHCC, if assessment is not required as part of the services being provided.  Note: There is no payment for travel time, wait time, no-shows or cancellations.  Unit = fifteen (15) minutes
<b>Re- Authorization</b>	Not applicable
<b>Discharge Criteria</b>	At least <u>one</u> (1) of the following criteria are met: 1. The assessment and feedback session have been completed and the written report submitted to MHCC, meets clinical and service content standards as determined by the Clinical Psychologist. Evaluations not meeting these standards will be returned to the evaluator with suggested changes/concerns identified; 2. The young adult or youth/family no longer wants to participate in this service and revokes consent <sup>9</sup> ; or 3. The young adult or youth is no longer eligible for SEBD program. As part of discharge, the MHCC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible.
<b>Service Exclusions</b>	1. Young adult or youth with a Mental Health Assessment current within one (1) year or those being referred for a Comprehensive Mental Health Assessment or a Focused Mental Health Assessment. 2. The service currently being provided is require to conduct the assessment as part of the services offered.
<b>Clinical Exclusions</b>	Young adult or youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior.

### Staffing Requirements:

1. The provider of a Summary Annual Assessment shall meet one (1) of the following requirements:
  - a. Credentialed by CAMHD as a Qualified Mental Health Professional (QMHP);
  - OR**
  - b. Credentialed by CAMHD as a Mental Health Professional (MHP);
  - AND**
  - c. Working under the supervision of a QMHP above. The supervisor is expected to review all data on which the current report is based, and participate in the interpretation of data and the development of the diagnoses and recommendations. The supervisor is to co-sign the report acknowledging supervisory responsibility for the assessment.
2. Assessors are to follow all applicable professional practice standards and ethical guidelines.

<sup>9</sup> If the young adult or youth/family revokes consent or refuses to release the report to CAMHD, they will be liable for the cost of this service.

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

### Clinical Operations

1. Direct service providers shall collaborate with family/significant others and with other systems of care partners such as education, juvenile justice, child welfare as needed to provide coordinated services.
2. Direct service providers must obtain consents for assessments.
3. Report contains all service content components described in the documentation section.
4. Report is typed.
5. Report is submitted to MHCC within twenty (20) working days of referral and authorization.

### Documentation

Complete written report is due within twenty (20) working days from date of referral and authorization. Written report includes all of the following, highlighting information about the past year and information gained since the last assessment:

1. Date(s) of assessment and date of report;
2. Identifying information: young adult or youth name, DOB, legal guardian, home school, grade level, IDEA status;
3. Sources of information: including review of records, interviews, and assessment tools;
4. Significant changes and/or new information regarding developmental, medical, family, social, educational, legal, substance abuse, medical and psychiatric status, exposure to trauma and use of and reasons for psychotropic medications;
5. Summary of treatment and progress over the past year;
6. Behavioral observations and mental status exam;
7. Assessment results and interpretation from the Achenbach(s), CASII and CAFAS/PECFAS; must include specific scores from these instruments and clear interpretations;
8. Description of young adult or young adult or youth and family strengths including formal and informal supports and highlighting newly developed strengths;
9. Clinical formulation and justification of diagnosis;
10. Diagnostic impressions: DSM IV-5 axes;
11. Summary of strengths, concerns, and description of needs that must be met for youth/young adult to function adequately in his/her home and community;
12. Strength-based recommendations for any needed changes in the service plan should be included, with suggested goals and measurable objectives. Recommendations will conform to the following:
  - a. Supported by research evidence;
  - b. Describe and address the needs of the young adult or youth and family and build upon strengths;
  - c. Avoid specifying a particular services, program or eligibility status. For example, it should not be specified that young adult or youth needs "residential treatment." Instead, recommendations should focus on young adult or youth's particular needs, e.g. "the young adult or youth is in need of close supervision due to...";
  - d. Include treatment interventions that are provided in the least restrictive manner that will address the needs of the young adult or youth and family. These may include therapeutic interventions or behavior support strategies;
  - e. Report is signed by the assessor (and his/her supervisor when applicable) acknowledging responsibility for the assessment.



## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### E. PSYCHIATRIC EVALUATION

<b>Definition</b>	Psychiatric diagnostic examination, specifically completed by a American Board of Psychiatry and Neurology Board Eligible/Certified Child Psychiatrist, includes history, mental status exam, physical evaluation or exchange of information with the primary physician, and disposition. This service is limited to an initial or follow-up evaluation for medically complex or diagnostically complex young adult or youth. This evaluation does not involve psychiatric treatment or medication management.
<b>Services Components</b>	<ol style="list-style-type: none"> <li>1. Provider is responsible for contacting the young adult or family to set up an appointment within one (1) week of referral and authorization. The evaluation interview(s) and data gathering shall be completed within fifteen (15) shall be submitted to the CAMHD Branch within twenty (20) working days from referral and authorization.</li> <li>2. The psychiatrist is expected to review all previously collected data prior to interviewing young adult or youth and family.</li> <li>3. Psychiatric diagnostic evaluation of a patient includes examination of a patient or exchange of information with the primary physician, current mental health treatment providers, the child's school, other informants such as nurses or family members, and the preparation of a report. This baseline initial evaluation includes vital signs (blood pressure and pulse), height, weight, and neurological examination for abnormal movements (using a standardized format such as the AIMS) as well as mental status finding and other appropriate clinical measurements. A detailed history of previous medication trials and the results of such trials is a necessary component of service. The use of systematic and thorough diagnostic interviewing is encouraged.</li> <li>4. A written report is generated to document the nature, chronicity and severity of the disorder, DSM-IV diagnosis and Biopsychosocial recommendations regarding treatment interventions/medication. All recommendations shall be based on the presenting needs of the young adult or youth and family following evidence based practices and AACAP practice guidelines. A report must be submitted to the MHCC within twenty (20) working days from referral and authorization. The report will include the following; <ol style="list-style-type: none"> <li>a. Behavioral observations and general presentation;</li> <li>b. Description and history of presenting problems;</li> <li>c. Description of current medical issues;</li> <li>d. Any on-going substance use;</li> <li>e. Current medications;</li> <li>f. Complete Mental Status Examination including current CASII;</li> <li>g. Clinical formulation/Justification of Diagnoses (include severity and duration of diagnoses; for Rule/Out or Provisional diagnoses, explain what needs to occur to obtain a more definite diagnosis);</li> </ol> </li> </ol>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<ul style="list-style-type: none"> <li>h. Diagnostic impression: DSM-IV –5 Axes;</li> <li>i. Discussion of findings and recommendations with young adult or youth and family including fully explaining the benefits, risks, and alternatives;</li> <li>j. Reference of adherence to evidenced-based psychopharmacological practice; and</li> <li>k. Recommendations must include what benefits may or may not be expected from the medication in a manner measurable by client, family, and significant members of the treatment team, and how the medication may specifically assist any other concurrent treatments.</li> </ul> <p>5. Assure that services are provided to young adult or youth in a safe, efficient manner in accordance with accepted standards and clinical practice.</p>
<b>Admission Criteria</b>	<p><u>All</u> of the following criteria are met:</p> <ul style="list-style-type: none"> <li>1. The identified young adult or youth meets SEBD Eligibility criteria for CAMHD (See Appendix B-7), is registered with a Branch and has an assigned MHCC;</li> <li>2. The young adult or youth presents as a medically complex or diagnostically complex needing an initial or follow-up evaluation; and</li> <li>3. Clinical case review with the Clinical Director results in the determination that Psychiatric Diagnostic Evaluation may be beneficial to the client;</li> </ul>
<b>Initial Authorizations</b>	<p>Authorization may be to eight (8) units with approval from the Branch Chief.</p> <p>Unit = fifteen (15) minutes</p>
<b>Re-Authorization</b>	<p>Re-authorization of an additional four (4) units may be approved by the Branch Chief if:</p> <ul style="list-style-type: none"> <li>1. The evaluating psychiatrist identifies the need for additional authorization and notifies the MHCC for Branch Chief review and approval for one (1) of the following reasons: <ul style="list-style-type: none"> <li>a. The young adult or youth's symptoms and/or maladaptive behaviors during the assessment interviews persist at a level of severity such that a complete evaluation has not been achieved;</li> </ul> <p style="text-align: center;"><b>OR</b></p> <li>b. New symptoms, maladaptive behaviors, or medical complications have appeared during the interview process which require an additional session to evaluate.</li> </li></ul>
<b>Discharge Criteria</b>	<p>At least <u>one</u> (1) of the following must be met:</p> <ul style="list-style-type: none"> <li>1. The Psychiatric Diagnostic Evaluation was successfully completed and a written report provided to the MHCC and is reviewed and accepted by the Branch Chief or Clinical Director. Evaluations not meeting these standards will be</li> </ul>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p>returned to the evaluator with suggested changes/concerns identified;</p> <ol style="list-style-type: none"><li>2. Young adult or youth exhibits new symptoms or maladaptive behavior, which preclude the ability to safely or effectively complete the evaluation, and young adult or youth was referred to a more intensive level of care;</li><li>3. The young adult or youth/family no longer wants to participate in this service and revokes consent with no imminent danger to self or others<sup>10</sup>; or</li><li>4. The young adult or youth no longer eligible for CAMHD SEBD program. As part of discharge, the MHCC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible.</li></ol>
<b>Service Exclusions</b>	<ol style="list-style-type: none"><li>1. Not offered at the same time as Acute Psychiatric Hospitalization, Hospital Based Residential, Partial Hospitalization, and Community-based Residential Level I, II and III, or Community-based Clinical Detoxification.</li><li>2. Psychiatric Diagnostic Evaluation is not a stand-alone service, but is part of a larger treatment plan.</li></ol>
<b>Clinical Exclusions</b>	Young adult or youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior.

### Clinical Operations

1. The provider of the Psychiatric Evaluation must be a CAMHD credentialed QMHP meeting the following:
  - a. Must be a current Hawaii-licensed psychiatrist; board certified by the American Board of Psychiatry and Neurology (ABPN); and board certified or board eligible in Child/Adolescent Psychiatry. QMHP Psychiatrists in hospital-based settings must be ABPN board certified in Child/Adolescent Psychiatry.
2. Direct service providers must obtain consents for assessments.
3. Report contains all service content components.
4. Report is typed.
5. Report is submitted to MHCC within twenty (20) working days of referral and authorization.

### Documentation

A complete written report is due to the within twenty (20) working days from date of referral and authorization. The written report is generated to document the nature, chronicity, and severity of the disorder, and recommendations regarding medication. The report will include the following:

1. Date(s) of assessment and date of report;
2. Identifying information: young adult or youth name, DOB, legal guardian, home school, grade level, IDEA status;
3. Reason for referral;
4. Description and history of presenting problem;
5. Sources of information: including review of records, interviews, and assessment tools;

---

<sup>10</sup> If the young adult or youth/family revokes consent or refuses to release the report to CAMHD, they will be liable for the cost of this service.

## **INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES**

---

6. Substance use history;
7. Description and history of presenting problems;
  - a. Behavioral observations and general presentation;
  - b. Description and history of presenting problems;
  - c. Description of current medical issues;
  - d. Any ongoing substance use;
  - e. Current medications;
  - f. Complete Mental Status Examination including CASII;
  - g. Clinical formulation/Justification of Diagnoses (including severity and duration of diagnoses; for Rule/Out or Provisional diagnoses, explain what needs to occur to obtain a more definite diagnosis);
  - h. Diagnostic impression: DSM-IV – 5 Axes;
  - i. Discussion of findings and recommendations with young adult or youth and family including fully explaining the benefits, risks, and alternatives;
  - j. Reference of adherence to evidenced-based psychopharmacological practice;
  - k. Recommendations must include what may or may not be expected from the medication in a manner measurable by client, family and significant members of the treatment team, and how the medication may specifically assist any other concurrent treatments; and
  - l. Report is signed by the assessor acknowledging responsibility for the assessment.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### F. MEDICATION MANAGEMENT

<b>Definition</b>	The ongoing assessment of the young adult or youth's response to medication, symptom management, side effects, adjustment and/or change in medication and in medication dosage. Routine medication management is provided by an American Board of Psychiatry and Neurology Board Eligible/Certified Child Psychiatrist or a Licensed Advanced Practical Registered Nurse with prescription privileges.
<b>Services Components</b>	Medication Management may includes the following tasks: <ol style="list-style-type: none"> <li>1. Assessing the young adult or youth's ongoing need for medication;</li> <li>2. Reference and adherence to evidence-based psychopharmacological practices;</li> <li>3. Determining overt physiological effects related to the medications used in the treatment of the young adult or youth's psychiatric condition, including side effects;</li> <li>4. Determining psychological effects of medications used in the treatment of the young adult or youth's psychiatric condition using appropriate Rating Scales;</li> <li>5. Monitoring compliance to prescription medication;</li> <li>6. Determining impact of medication use on other components of the client's treatment;</li> <li>7. Renewing prescription(s);</li> <li>8. Appropriate monitoring of height, weight, vital signs, laboratory test, and neurologic findings in a standardized format such as the AIMS when appropriate;</li> <li>9. Direct observation and assessment as described above are necessary components of medication monitoring; and</li> <li>10. Full documentation of Informed Consent, including a signed description of potential benefits and possible side effects of the prescribed medication, that must be placed in the clinical record prior to initiation of medication. The Consent must be signed and dated by the young adult or youth's parent(s) or legal guardian.</li> </ol>
<b>Admission Criteria</b>	<u>All</u> of the following criteria are met: <ol style="list-style-type: none"> <li>1. The identified young adult or youth meets SEBD Eligibility criteria for CAMHD (See Appendix B-7), is registered with a Branch and has an assigned MHCC;</li> <li>2. The young adult or youth has been evaluated by a psychiatrist, and is deemed in need of medication to treat a behavioral, or other psychiatric disorder to prevent admission to a more restrictive or intensive service level;</li> <li>3. Once prescribed medication, the young adult or youth requires ongoing monitoring for effectiveness and adverse reactions and renewing prescriptions at frequencies consistent with accepted practice. Ongoing routine management requires at least quarterly (every third month) monitoring and documentation; and</li> <li>4. The CSP includes this service and measurable objectives for</li> </ol>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	outcomes of this service prior to admission.
<b>Initial Authorizations</b>	Authorization may be up to four (4) units for the first three (3) months with approval of the Branch Chief.  Unit = fifteen (15) minutes
<b>Re-Authorization</b>	Reauthorization is for four (4) units at least quarterly once medications are effectively regulating the affective, behavioral, thought disorder with approval of the Branch Chief.  Ongoing medication monitoring requires discussion between CAMHD Branch personnel and the contract provider regarding the patient's adjustment.  Unit = fifteen (15) minutes
<b>Discharge Criteria</b>	At least <u>one</u> (1) of the following must be met: <ol style="list-style-type: none"><li>1. The young adult or youth's symptoms have stabilized and all medications have been discontinued;</li><li>2. The young adult or youth and family no longer desire psychopharmacological interventions and have withdrawn consent, therefore, the medications have been discontinued; and</li><li>3. Young adult or youth no longer meets eligibility criteria for SEBD program. As part of discharge, psychiatrist will coordinate the transfer of the young adult or youth to appropriate treatment services in the least disruptive manner possible.</li></ol>
<b>Service Exclusions</b>	<ol style="list-style-type: none"><li>1. Not offered at the same time as Acute Psychiatric Hospitalization, Hospital Based Residential, Partial Hospitalization, Community-based Residential Levels I, II and III, and Community-based Clinical Detoxification.</li><li>2. Medication Management is not a stand alone service, but is part of a larger treatment plan and young adult or youth and family is actively engaged treatment.</li></ol>
<b>Clinical Exclusions</b>	Young adult or youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior. Once stable, young adult or youth who otherwise meet the eligibility criteria may be referred for medication monitoring.

### Staffing Requirements

1. The provider of the Medication Management must be a CAMHD credentialed QMHP meeting the following:
  - a. Must be a current Hawaii-licensed psychiatrist; board certified by the American Board of Psychiatry and Neurology (ABPN); and board certified or board eligible in Child/Adolescent

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

Psychiatry. QMHP Psychiatrists in hospital-based settings must be ABPN board certified in Child/Adolescent Psychiatry; or

- b. An Advanced Practice Registered Nurse (APRN) certified as a Psychiatric Clinical Nurse Specialist with a current Hawaii license/certification with prescription privileges.

### Clinical Operations

1. Direct service providers must coordinate with family/significant others and with other systems of care such as education, juvenile justice system, child welfare as needed to provide service.
2. Direct service providers must obtain consents for treatment.
3. Service must be preceded by assessment of young adult or youth.

### Documentation

1. A progress note must be placed within the patient's record within twenty-four (24) hours of the date of service.
2. The progress note must include all of the following information:
  - a. Name of patient and CR#;
  - b. The date, actual time and duration of the services rendered;
  - c. The signature of the Psychiatrist who rendered the service;
  - d. The place of service;
  - e. Current medications the young adult or youth is taking including dosage and intervals when medication is to be administered;
  - f. Side effects or adverse reactions the young adult or youth is experiencing;
  - g. Conditions in which the young adult or youth is refusing or unable to take medications as ordered or if the young adult or youth is compliant in taking medications as prescribed;
  - h. Whether the medication (s) is effectively controlling symptoms;
  - i. Implications for other components of the client's treatment;
  - j. Any results from laboratory testing; and
  - k. Results of any Rating Scales employed.
3. Please see Section I General Standards for additional documentation requirements:
  - E. Service Planning:
    - Discharge Summary;
  - O Minimum Reporting Requirements:
    - Monthly Treatment and Progress Summary.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### G. INDIVIDUAL THERAPY

<b>Definition</b>	Regularly scheduled face-to-face therapeutic services with a youth or young adult focused on improving his/her individual functioning. Individual therapy includes interventions such as cognitive-behavioral strategies, behavioral plans, skills training, systemic interventions, crisis planning and facilitating access to other community services and supports. These therapy services are designed to promote healthy independent functioning and are intended to be focused and time-limited, with interventions reduced and discontinued as the young adult or youth and family are able to function more effectively. The usual course of treatment is six (6) to twenty-four (24) sessions or six (6) months. This service most often will be provided in conjunction with at least occasional family therapy sessions.
<b>Services Components</b>	<p>The provider must initiate services within two (2) weeks of referral and authorization unless otherwise indicated by the MHCC.</p> <ol style="list-style-type: none"> <li>1. Specific services include <u>all</u> of the following: <ol style="list-style-type: none"> <li>a. Access and review all historical and assessment data available in the young adult or young adult or youth's clinical record;</li> <li>b. Meet with the young adult or youth and relevant family members in order to engage them in the treatment process and assess and identify relevant issues, needs, and goals for treatment planning;</li> <li>c. Develop a written MHTP in collaboration with the young adult or youth and family;</li> <li>d. Involve other relevant parties in treatment planning (such as schools, psychiatric providers, extended family members) as indicated and with the permission of the young adult or family. Regular consultation sessions with the parent(s) or guardian(s) will be conducted as appropriate;</li> <li>e. Conduct regular sessions to work with young adult or youth to facilitate his/her ability to cope and function in a healthy manner through encouragement, support, evidenced-based therapy, education, skills training, and linkages to appropriate community services and resources;</li> <li>f. Review interventions, needs, goals and progress with the young adult or youth and family monthly and adjust the treatment plan as needed; and</li> <li>g. Assist with discharge planning in collaboration with MHCC. This may include participation in transitional therapy sessions if the young adult or youth is transferred to a new level of care or new provider(s).</li> </ol> </li> </ol>
<b>Admission Criteria</b>	<p><u>All</u> of the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. The identified young adult or youth meets SEBD Eligibility criteria for CAMHD (See Appendix B-7), is registered with a Branch and has an assigned MHCC;</li> </ol>



## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<ol style="list-style-type: none"> <li>2. The CSP includes this service and measurable objectives for outcomes of this service prior to admission;</li> <li>3. The young adult or youth must be identified as needing extra support increase coping skills and/or manage psychiatric illness; and</li> <li>4. There is reasonable expectation that the young adult or youth will benefit from this service, i.e., that therapy will remediate symptoms and/or improve functioning.</li> </ol>
<b>Initial Authorizations</b>	<p>Authorization may be up to sixteen (16) units per month for three (3) months by the MHCC.</p> <p>The total time in individual and family therapy sessions is not expected to exceed three hours a week. If more intensive services are needed past a temporary crisis, the family should be referred to another more intensive service (i.e. MST or Intensive In-Home)</p> <p>Note: Telephone contacts and logistical planning/preparation is included in the unit cost. There is no payment for phone calls, travel time, wait time, no-shows, or cancellations.</p> <p>Unit = fifteen (15) minutes</p>
<b>Re-Authorization</b>	<p>Reauthorization may be up to sixteen (16) units per month for three (3) months with approval of the MHS1.</p> <p>Need for continuation of services longer than six months is reviewed monthly by the Clinical Psychologist.</p> <p>Unit = fifteen (15) minutes</p>
<b>Continuing Stay Criteria</b>	<p><u>All</u> of the following criteria must be met as determined by clinical review of service documentation, plans and progress:</p> <ol style="list-style-type: none"> <li>1. The young adult or youth wants to continue to participate;</li> <li>2. Services are being provided per MHTP/CSP as documented in monthly progress summaries and plan reviews;</li> <li>3. There are regular and timely progress reviews and documentation of young adult or youth's response to interventions. Timely and appropriate modifications to the MHTP are made that are consistent with the young adult or youth's status;</li> <li>4. At least <u>one</u> (1) of the following criteria must be met: <ol style="list-style-type: none"> <li>a. Young adult or youth is demonstrating progress, but goals have not yet been met, there is reason to believe that goals can be met with ongoing therapy services;</li> <li>b. Minimal progress toward treatment goals has been demonstrated, there is reason to believe that goals can be met with ongoing therapy services;</li> </ol> </li> </ol>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<ul style="list-style-type: none"> <li>c. Symptoms or behaviors persist at a level of severity that was documented upon admission, and the projected time frame for attainment of treatment goals has not been reached. However, a less restrictive service would not adequately meet the young adult or youth's needs, and other more intensive services are not considered appropriate at this time. The treatment plan has been adjusted and there is reason to anticipate improved response to the planned approaches;</li> <li>d. New symptoms have developed, and the behaviors and the behavior can be safely and effectively addressed through individual therapy services with an updated treatment plan; and</li> <li>e. When services are being provided after six (6) months of individual therapy, the Clinical Psychologist has determined that an appropriate evidenced-base approach is being utilized and it is being provided with adequate fidelity to the model.</li> </ul>
<b>Discharge Criteria</b>	<p>Young adult or youth is no longer in need of or eligible for service due to at least <u>one</u> (1) of the following:</p> <ul style="list-style-type: none"> <li>1. Targeted symptoms and/or maladaptive behaviors have abated to a level of severity which no longer requires this level of care as documented by attainment of goals in the treatment plan;</li> <li>2. Young adult or youth has demonstrated minimal or no progress toward treatment goals for a three (3) month period and appropriate modifications of plans have been made and implemented with no significant success, suggesting the young adult or youth is not benefiting from individual therapy services at this time;</li> <li>3. Young adult or youth exhibits new symptoms and/or maladaptive behaviors which cannot be safely and effectively addressed through individual therapy services;</li> <li>4. Young adult or youth or family is not willing to continue to participate in the services and revoke consent with no imminent danger to self or others;</li> <li>5. The young adult or youth is no longer eligible for SEBD services. As part of discharge, the MHCC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible;</li> </ul>
<b>Service Exclusions</b>	<p>Not offered at the same time as all any Out-of-Home service, Intensive In-Home Intervention or Intensive Outpatient services, unless the individual therapy is specialized and designed to address a specific and targeted problem area (e.g. sexual offending behavior) is needed to augment other services. It can be authorized with review and approval of the Clinical Psychologist.</p>

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

<b>Clinical Exclusions</b>	Young adult or youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior. Once stable, young adult or youth who otherwise meet the eligibility criteria may be referred to this service;
----------------------------	---

### Staffing Requirements:

1. In addition to the staffing requirement listed in the general standards, these staff requirements must also be followed. If the standards referenced here differ from those in the general standards, these staffing requirements will supersede the general standards.
2. Individual therapy services shall be provided by personnel that meet one (1) of the following requirements:
  - a. Credentialed by CAMHD as a Qualified Mental Health Professional (QMHP);
  - OR**
  - b. Credentialed by CAMHD as a Mental Health Professional (MHP);
  - AND**
  - c. Working under the supervision of a QMHP. The supervisor is expected to review all of the supervisees work in detail.
3. Providers are to follow all applicable professional practice standards and ethical guidelines.

### Clinical Operations

1. Direct service providers shall coordinate with family/significant others and with other systems of care such as education, juvenile justice system, child welfare as needed to provide service.
2. Please see Section I General Standards for additional clinical operation requirements:
  - D. Co-Occurring Disorders;
  - F. Referral Process for Services:
    - Referral Acceptance;
  - G. CAMHD Continuity of Care;
  - H. Staffing;
  - I. Supervision;
  - J. Evaluation of Staff Performance;
  - K. Credentialing Requirements;
  - N. Service Quality;
  - O. Minimum Reporting Requirements;
  - P. Risk Management:
    - Criminal, Child Abuse, and Background Screening;
    - Safety;
    - Restraints and Seclusion;
    - Sentinel Events and Incidents;
    - Police.

### Documentation

1. Please see Section I General Standards for documentation requirements:
  - E. Service Planning:
    - Mental Health Treatment Plan including transition, crisis and discharge planning;
    - Discharge Summary;
  - M. Maintenance of Service Records:

- Progress Notes;
- O. Minimum Reporting Requirements:
  - Monthly Treatment and Progress Summary;

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### H. GROUP THERAPY

<b>Definition</b>	Regularly scheduled, face-to-face therapeutic services for groups of three or more young adult or youth for the purpose of addressing symptoms/problems that prevent the development of healthy functioning in the home, school or community. These therapy services are designed to teach specific skills for addressing the symptoms associated with defined disorders or challenges and to provide support for the use of these skills. Group Therapy services are focused and time-limited. This service can include groups that address young adult or youths' needs utilizing a "multi-family group" format, in which the parents or guardian attend the group along with the young adult or youth.
<b>Services Components</b>	<ol style="list-style-type: none"> <li>1. Group therapy services include regularly scheduled face-to-face interventions with three (3) or more youth or young adults that are designed to improve home and community functioning in the most natural and appropriate setting. A co-therapist is required for groups of six (6) or more. Groups are focused and time-limited, and young adult or youth may be discharged from the group as targeted goals are reached depending on the structure of the group.</li> <li>2. Evidence-based treatments are utilized to structure groups. Group therapies may involve verbal instruction and education, modeling, coaching, role-playing, behavioral practice and other group-oriented experiential modalities.</li> <li>3. Specific goals may include: symptom reduction; increased behavioral control; improved communication; social, coping; anger management; problem solving; and other daily living skills. Interventions should be tailored to address identified young adult or youth needs. Services are designed to promote healthy independent functioning and to build upon the natural strengths of the young adult or youth and community.</li> <li>4. Because of the research evidence that group therapy may have risks for disruptive behavior, delinquency, willful misconduct, substance abuse, and some types of eating disorders, particular care is to be used to assure that only appropriately structured, evidence-based treatments are used with these young adult or youth and that inappropriate young adult or youth are not included in groups.</li> <li>5. The provider must begin contacting the young adult or youth/family within one (1) week of referral and initiate service within four (4) weeks of authorization, unless otherwise indicated by the MHCC.</li> <li>6. Specific services include <u>all</u> of the following: <ol style="list-style-type: none"> <li>a. Accessing and reviewing all historical and assessment data available in the young adult or youth's clinical record;</li> <li>b. Meeting with the young adult or youth and family to identify relevant issues, needs, and related goals to aid in treatment planning and determine whether a planned</li> </ol> </li> </ol>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p>group will meet the needs of the youth/young adult;</p> <ul style="list-style-type: none"> <li>c. Participating in phone consultation with the MHCC to promote the integration of services across domains (home, community) as needed;</li> <li>d. Implementing, monitoring, and adjusting interventions as needed to address needs and accomplish objectives and goals of the group; and</li> <li>e. Conducting regular group sessions to work with young adult or youth to address identified needs and goals per treatment plan.</li> </ul>
<b>Admission Criteria</b>	<p><u>All</u> of the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. The identified young adult or youth meets SEBD Eligibility criteria for CAMHD (See Appendix B-7), is registered with a Branch and has an assigned MHCC;</li> <li>2. The young adult or youth must be between the ages of seven (7) to twenty-one (21);</li> <li>3. The CSP includes this service and measurable objectives for outcomes of this service prior to admission;</li> <li>4. There is a reasonable expectation that the young adult or youth will benefit from this service, i.e., that group therapy will remediate symptoms and/or improve functioning that relate to improved ability to function in the most natural environment; and</li> <li>5. The youth or young adult has not been able to be successful in community activities such as organized sports, Boys and Girls Clubs, scouting etc. which might address the same goals as the planned group (such as developing social skills, increasing self-esteem, etc.).</li> </ol>
<b>Initial Authorizations</b>	<p>The MHCC may authorization up to one (1) group sessions per week for up to three (3) months.</p> <p>If sessions are one (1) hour, sixteen (16) units per month can be authorized. If sessions are two (2) hours, thirty-two (32) units per month can be authorized.</p> <p>Note: Billable time is limited to time spent in face-to-face therapy with young adult or youth. Telephone contacts and logistical planning/preparation is included in the unit cost. There is no payment for travel time, wait time, no-shows, or cancellations.</p> <p>In the case of multi-family groups, providers can bill for the youth only.</p> <p>Unit = fifteen (15) minutes.</p>
<b>Re-Authorization</b>	<p>Reauthorization may be up to a three (3) additional months with approval of the MHS1. The units authorized will depend on the planned length of each group session.</p>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p>Any request for authorization beyond six (6) months must be approved by the Clinical Psychologist.</p> <p>Unit = fifteen (15) minutes.</p>
<b>Continuing Stay Criteria</b>	<p><u>All</u> of the following criteria must be met as determined by clinical review of service documentation, plans and progress every three (3) months following admission:</p> <ol style="list-style-type: none"> <li>1. The evidence-based group therapy program has not been completed;</li> <li>2. Young adult or youth is willing to continue to participate;</li> <li>3. Services are being provided per CSP/MHTP as documented in progress summaries and plan reviews;</li> <li>4. There are regular and timely assessments and documentation of young adult or youth's response to the treatment plan are made that are consistent with the young adult or youth's status;</li> <li>5. At least <u>one</u> (1) of the following criteria must be met: <ol style="list-style-type: none"> <li>a. Young adult or youth is demonstrating progress, but goals have not yet been met, and there is reason to believe that goals can be met with ongoing therapy services;</li> <li>b. Minimal progress toward treatment goals has been demonstrated, and there is reason to believe that goals can be met with ongoing therapy services;</li> <li>c. Symptoms or behaviors persist at a level of severity that was documented upon admission, and the projected time frame for attainment of treatment goals has not been reached. However, a less restrictive service would not adequately meet the youth's or young adult's needs, and other more intensive services are not considered appropriate at this time. The treatment plan has been adjusted and there is reason to anticipate improved response to the planned approaches;</li> <li>d. New symptoms have developed, and the behaviors can be safely and effectively addressed through therapy services with an updated treatment plan; and</li> <li>e. When service are being reviewed after more than six (6) months of group therapy, the Clinical Psychologist has determined that an appropriate, evidence-based approach is being utilized and it is being provided with adequate fidelity to the model.</li> </ol> </li> </ol>
<b>Discharge Criteria</b>	<p>Young adult or youth is no longer in need of or eligible for this level of service when at least <u>one</u> (1) of the following occurs:</p> <ol style="list-style-type: none"> <li>1. The evidenced based, group therapy program has been completed;</li> <li>2. Targeted symptoms and/or maladaptive behaviors have abated to a level of severity which no longer requires this level of care as documented by attainment of goals;</li> <li>3. Young adult or youth has demonstrated minimal or no</li> </ol>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p>progress toward treatment goals for a three month period, suggesting the young adult or youth is not benefiting from group therapy services at this time;</p> <ol style="list-style-type: none"><li>4. Young adult or youth exhibits new symptoms which cannot be safely and effectively addressed through group therapy services;</li><li>5. Young adult or youth is no longer willing to participate in this service; or</li><li>6. The youth or young adult is no longer eligible for SEBD services. As part of discharge, the MHCC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible.</li></ol>
<b>Service Exclusions</b>	<p>Not offered at the same time as all any Out-of-Home service, Intensive In-Home Intervention or Intensive Outpatient service, unless the Group Therapy is specialized and designed to address a specific and targeted problem area (e.g. sexual offending behavior) is needed to augment other services. It can be authorized with review and approval of the Clinical Psychologist.</p>
<b>Clinical Exclusions</b>	<ol style="list-style-type: none"><li>1. Young adult or youth in need of immediate crisis stabilization because of active suicidal, homicidal or psychotic behavior. Once stable, young adult or youth who otherwise meet the eligibility criteria may be referred into this service;</li><li>2. Because group interventions pose risks for youth or young adults with disruptive behavior, delinquency, willful misconduct, substance abuse, and some types of eating disorders, youth/young adults with these diagnoses should be offered only well-structured, evidence-based group interventions and only when the potential benefits are judged to outweigh the potential risks (e.g. a highly structured coping skills group for youth who engages in self-harm behavior when upset and who also shows mis-conduct).</li></ol>

### Staffing Requirements:

1. Group therapy services shall be provided by personnel that meet one (1) of the following requirements:
  - a. Credentialed by CAMHD as a Qualified Mental Health Professional (QMHP);

**OR**

  - b. Credentialed by CAMHD as a Mental Health Professional (MHP);

**AND**

  - c. Working under the supervision of a QMHP. The supervisor is expected to review all of the supervises work in detail.
2. Providers are to follow all applicable professional practice standards and ethical guidelines.

### Clinical Operations

1. In addition to the staffing requirement listed in the general standards, these staff requirements must also be followed. If the standards referenced here differ from those in the general standards, these staffing requirements will supersede the general standards.



---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

2. Direct service providers shall coordinate with family/significant others and with other systems of care such as education, juvenile justice system, child welfare as needed to provide service.
3. Please see Section I General Standards for additional clinical operation requirements:
  - D. Co-Occurring Disorders;
  - F. Referral Process for Services:
    - Referral Acceptance;
  - G. CAMHD Continuity of Care;
  - H. Staffing;
  - I. Supervision;
  - J. Evaluation of Staff Performance;
  - K. Credentialing Requirements;
  - N. Service Quality;
  - O. Minimum Reporting Requirements;
  - P. Risk Management:
    - Criminal, Child Abuse, and Background Screening;
    - Safety;
    - Restraints and Seclusion;
    - Sentinel Events and Incidents;
    - Police.

### Documentation

1. Please see Section I General Standards for documentation requirements:
  - E. Service Planning:
    - Mental Health Treatment Plan including transition, crisis and discharge planning;
    - Discharge Summary;
  - M. Maintenance of Service Records:
    - Progress Notes;
  - O. Minimum Reporting Requirements:
    - Monthly Treatment and Progress Summary.
2. Progress notes for Group Therapy must be individualized for each group member and providers must take care to guard the confidentiality of other group members in writing the note.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### I. FAMILY THERAPY

<b>Definition</b>	Regularly scheduled face-to-face interventions with a young adult or youth and his/her family, designed to improve young adult or youth/family functioning and treat the young adult or youth's emotional challenges. The family therapist helps the young adult or youth and family increase their use of effective coping strategies, healthy communication, and constructive problem-solving skills. The therapist also provide psycho-education about the nature of the young adult or youth's diagnosis. Frequently, Family Therapy sessions are held in the course of on-going Individual Therapy in order to provide opportunities for the therapist to consult with the parent(s) or guardian(s) and review progress toward goals. Family Therapy services are designed to be time-limited with interventions reduced and then discontinued, as young adult or youth/family are able to function more effectively.
<b>Services Components</b>	<ol style="list-style-type: none"> <li>1. The young adult or youth almost always is present for family therapy sessions. There are occasions where it is clinically indicated that the young adult or youth not be present, the reasons are documented in progress notes and monthly progress summaries. Specific interventions may include:               <ol style="list-style-type: none"> <li>a. Assist the family with developing and maintaining appropriate structure within the home;</li> <li>b. Assist the family to develop effective parenting skills and child behavior management techniques;</li> <li>c. Assist the family to develop increased understanding of the youth/young adult's symptoms and problematic behaviors, to develop effective strategies to address these issues, and to build upon strengths;</li> <li>d. Facilitate effective communication and problem solving between family members; and</li> <li>e. Facilitate effective communication between family members and other community agencies; and</li> <li>f. Facilitate linkages to community supports and resources.</li> </ol> </li> <li>2. Interventions are evidence-based and tailored to address identified young adult or youth and family needs. Services are designed to promote healthy functioning and build upon the natural strengths of the young adult or youth, family, and community;</li> <li>3. The provider must begin service within two (2) weeks of referral and authorization unless otherwise indicated by the MHCC. Specific services the therapist will provide include:               <ol style="list-style-type: none"> <li>a. Access and review the CSP and all historical and assessment data available in the young adult or youth's clinical record;</li> <li>b. Meet with the young adult or youth and relevant family members in order to engage them in the treatment process and identify relevant issues, needs, and related goals for treatment planning;</li> </ol> </li> <li>4. Involve other relevant parties in treatment planning (such as psychiatric providers and extended family members) as</li> </ol>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p>indicated and with the permission of the young adult or family;</p> <ol style="list-style-type: none"> <li>5. Implement, monitor, and adjust interventions as needed to address needs and accomplish objectives and goals;</li> <li>6. Conduct regular sessions to work with young adult or youth and family members together to address goals and objectives; and</li> <li>7. Participating in phone consultation with the MHCC to promote the integration of services across domains (home, community) as needed; and</li> <li>8. Assist with discharge planning in collaboration with the mental health treatment team, including participation in transitional therapy sessions if the family moves on to new.</li> </ol>
<b>Admission Criteria</b>	<p><u>All</u> of the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. The identified young adult or youth meets SEBD Eligibility criteria for CAMHD (See Appendix B-7), is registered with a Branch and has an assigned MHCC;</li> <li>2. The CSP includes this service and measurable objectives for outcomes of this service prior to admission; and</li> <li>3. There is reasonable expectation that the young adult or youth and family will benefit from this service, i.e., that family therapy will remediate symptoms and/or improve functioning in the home and community.</li> </ol>
<b>Initial Authorizations</b>	<p>The MHCC may authorization up to sixteen (16) units per month for three (3) months.</p> <p>The total time in Family and Individual Therapy sessions is not expected to exceed three (3) hours a week. If more intensive services are needed (beyond a temporary crisis), the family should be referred to another service (e.g. MST, Intensive In-Home Intervention or Functional Family Therapy).</p> <p>Note: Telephone contacts and logistical planning/preparation are included in the unit cost. There is no additional payment for phone calls, travel time, wait time, no-shows, or cancellations.</p> <p>Unit = fifteen (15) minutes</p>
<b>Re-Authorization</b>	<p>Reauthorization may be up to sixteen (16) units per month for three (3) months with review and approval by the MHS1.</p> <p>Any request for authorization beyond six (6) months must be approved by the Clinical Psychologist.</p> <p>Unit = fifteen (15) minutes</p>
<b>Continuing Stay Criteria</b>	<p><u>All</u> of the following criteria must be met as determined by clinical review of service documentation, plans and progress every three (3) months following admission:</p>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<ol style="list-style-type: none"> <li>1. Services are being provided per CSP/MHTP as documented in progress summaries and plan reviews;</li> <li>2. Young adult or youth and family are willing to continue to participate in the service;</li> <li>3. There are regular and timely assessments and documentation of young adult or youth/family's response to interventions. Timely and appropriate modifications to the treatment plan are made that are consistent with the young adult or youth/family's status; and</li> <li>4. At least <u>one</u> (1) of the following criteria must be met: <ol style="list-style-type: none"> <li>a. Young adult or youth is demonstrating progress, but goals have not yet been met, there is reason to believe that goals can be met with ongoing therapy services;</li> <li>b. Minimal progress toward treatment goals has been demonstrated and there is reason to believe that goals can be met with ongoing therapy services;</li> <li>c. Symptoms or behaviors persist at a level of severity that was documented upon admission, and the projected time frame for attainment of treatment goals as documented in the treatment plan has not been reached. However, a less restrictive level of care would not adequately meet young adult or youth's needs, and other more intensive services are not considered appropriate at this time. The treatment plan has been adjusted and there is reason to anticipate improved response to the planned approaches;</li> <li>d. New symptoms have developed, and the behaviors can be addressed safely and effectively through outpatient therapy services with an updated treatment plan; or</li> <li>e. When service are being reviewed after more than six (6) months of Family Therapy, the Clinical Psychologist has determined that an appropriate, evidence-based approach is being utilized and it is being provided with adequate fidelity to the model.</li> </ol> </li> </ol>
<b>Discharge Criteria</b>	<p>Young adult or youth and family are no longer in need of or eligible for this level of service due to at least <u>one</u> (1) of the following:</p> <ol style="list-style-type: none"> <li>1. Targeted symptoms have improved to a point where the youth/young adult no longer requires this level of care as documented by attainment of goals in the treatment plan;</li> <li>2. Young adult or youth and family have demonstrated minimal or no progress toward treatment goals for a three (3) month period and appropriate modification of plans have been made and implemented with no significant success, suggesting the young adult or youth and family is not benefiting from family therapy services at this time;</li> <li>3. Young adult or youth exhibits new symptoms and/or which cannot be addressed safely and effectively through Family Therapy services;</li> <li>4. Young adult or youth and family are not willing to continue with the service and/or have revoked consent with no imminent danger to self or others;</li> </ol>

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

	5. The youth is no longer eligible for SEBD services. As part of discharge, the MHCC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible.
<b>Service Exclusions</b>	<ol style="list-style-type: none"><li>1. Not offered at the same time as all any Out-of-Home service, Intensive In-Home or Multisystemic Therapy, Functional Family Therapy, or Intensive Outpatient service, unless the Family Therapy is specialized and designed to address a specific and targeted problem area (e.g. sexual offending behavior) is needed to augment other services. It can be authorized with review and approval of the Clinical Psychologist.</li><li>2. Family Therapy is not a stand-alone service, but is part of a larger treatment plan and the young adult/youth and family are actively engaged in treatment.</li></ol>
<b>Clinical Exclusions</b>	Young adult or youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior. Once stable, young adult or youth who otherwise meet the eligibility criteria may be referred into this service.

### Staffing Requirements:

1. Family Therapy services must be provided by personnel that meet one (1) of the following requirements:
  - a. Credentialed by CAMHD as a Qualified Mental Health Professional (QMHP);

**OR**

  - b. Credentialed by CAMHD as a Mental Health Professional (MHP);

**AND**

  - c. Working under the supervision of a QMHP. The supervisor is expected to review all of the supervisees work in detail.
2. Providers are to follow all applicable professional practice standards and ethical guidelines.

### Clinical Operations

1. Direct service providers shall coordinate with family/significant others and with other systems of care such as education, juvenile justice system, child welfare as needed to provide service.
2. Please see Section I General Standards for additional clinical operation requirements:
  - D. Co-Occurring Disorders;
  - F. Referral Process for Services:
    - Referral Acceptance;
  - G. CAMHD Continuity of Care;
  - H. Staffing;
  - I. Supervision;
  - J. Evaluation of Staff Performance;
  - K. Credentialing Requirements;
  - N. Service Quality;
  - O. Minimum Reporting Requirements;
  - P. Risk Management:
    - Criminal, Child Abuse, and Background Screening;
    - Safety;

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

- Restraints and Seclusion;
- Sentinel Events and Incidents;
- Police.

### Documentation

1. Please see Section I General Standards for documentation requirements:
  - E. Service Planning:
    - Mental Health Treatment Plan including transition, crisis and discharge planning;
    - Discharge Summary;
  - M. Maintenance of Service Records:
    - Progress Notes;
  - O. Minimum Reporting Requirements:
    - Monthly Treatment and Progress Summary.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### J. FUNCTIONAL FAMILY THERAPY

<b>Definition</b>	<p>This is an evidenced-base family treatment system provided in a home or clinic setting for youth experiencing one of a wide range of externalizing behavior disorders (e.g., conduct, violence, drug abuse) along with family problems (e.g., family conflict, communication) and often with additional co-morbid internalizing behavioral or emotional problems (e.g., anxiety, depression).</p> <p>The goals of FFT are:</p> <ol style="list-style-type: none"> <li>1. Phase I: Engagement of all family members and motivation of the youth and family to develop a shared family focus to the presenting problems;</li> <li>2. Phase II: Behavior change – target and change specific risk behaviors of individuals and families; and</li> <li>3. Phase III: Generalize or extend the application of these behavior changes to other areas of family relationships.</li> </ol> <p>FFT services range from eight to twelve (8 to 12) one-hour sessions for mild challenges, up to 30 hours of direct service (i.e., clinical sessions, telephone calls, and meetings involving community resources) for more difficult situations, and are usually spread over a three to six (3 to 6) month period. FFT can be conducted in a clinic setting, as a home based model or as a combination of clinic and home visits.</p>
<b>Services Offered</b>	<ol style="list-style-type: none"> <li>1. One (1)-to-two (2) hour therapy sessions with the clinician and the youth/family scheduled one (1) or two (2) times per week.</li> <li>2. Phase Task Analysis – a systemic and multiphasic intervention map used to identify treatment strategies.</li> <li>3. Ongoing assessment of family functioning to understand the ways in which behavioral problems function within the family.</li> <li>4. The use of formal and clinical tools for model, adherence, and outcome assessment.</li> <li>5. Clinical Services System (CSS) – an implementation tool that allows therapists to track the activities such as process goals, essential to successful outcomes.</li> <li>6. FFT therapist maintains collateral contacts with the MHCC.</li> <li>7. FFT therapist develops a mental health treatment plan in collaboration with the youth and family that includes a crisis plan and a discharge plan.</li> <li>8. Active, on-going treatment is based on measurable goals and objectives that are part of the youth's CSP and MHTP.</li> </ol>
<b>Admission Criteria</b>	<p><u>All</u> of the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. The identified youth meets SEBD Eligibility criteria for CAMHD (See Appendix B-7), is registered with a Branch and has an assigned MHCC;</li> <li>2. There must be a reasonable expectation that the youth and family can benefit from FFT services within three to six (3 to 6) months;</li> <li>3. The youth must have an adult/parental figure able to assume</li> </ol>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p>the long term parenting role and to actively participate with FFT service providers for the duration of treatment;</p> <ol style="list-style-type: none"> <li>4. The CSP identifies this service and measurable objectives for outcomes of this service prior to admission; and</li> <li>5. Youth are ages ten (10) through eighteen (18).</li> </ol>
<b>Initial Authorizations</b>	<p>Authorization may be up to ninety-six (96) units per day for one (1) month at a time for three (3) months by MHCC.</p> <p>Unit = fifteen (15) minutes</p>
<b>Re-Authorization</b>	<p>Re-authorization may be up to ninety-six (96) units per day for one (1) month at a time for three (3) months with approval from MHS1.</p> <p>Any request for re-authorization beyond six (6) months must be approved by the Clinical Psychologist.</p> <p>Unit = fifteen (15) minutes</p>
<b>Continuing Stay Criteria</b>	<p><u>All</u> of the following criteria are met as determined by treatment team review at least quarterly:</p> <ol style="list-style-type: none"> <li>1. All admission criteria continue to be met;</li> <li>2. Services/items are being provided as indicated in the CSP and MHTP and there are regular and timely assessments and documentation of youth/family response to services. Timely and appropriate modifications are made to services and plan as needed;</li> <li>3. The youth continues to have specific needs that indicate that Functional Family Therapy is the most appropriate means of addressing those needs; and</li> <li>4. There is a reasonable expectation that the youth will continue to make significant progress within the next months toward reaching the goals and objectives identified in the MHTP and CSP.</li> </ol>
<b>Discharge Criteria</b>	<p>Youth is no longer in need of or eligible for services due to at least <u>one</u> (1) of the following:</p> <ol style="list-style-type: none"> <li>1. The youth no longer eligible for CAMHD services. As part of discharge, the MHCC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible;</li> <li>2. The treatment team determines that service is no longer needed as there is a decrease in the identified problematic behavior and/or an increase in the developmentally appropriate pro-social behavior in home and community settings as documented in attainment of MHTP/CSP goals;</li> <li>3. The youth/family no longer wants to participate in this service and revokes consent with no danger to self or others;</li> <li>4. Targeted symptoms and/or maladaptive behaviors have abated to a level of severity which no longer requires this</li> </ol>



## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p>level of care as documented by attainment of goals in the MHTP and CSP;</p> <ol style="list-style-type: none"><li>5. Youth has demonstrated minimal or no progress toward treatment goals for a two (2) month period and appropriate modifications of the MHTP have been made and implemented with no significant success and the CSP team determines that the youth is not benefiting from this service at this time; or</li><li>6. Youth exhibits new symptoms and/or maladaptive behaviors which cannot be safely and effectively addressed through this service as determined by the CSP team.</li></ol>
<b>Service Exclusions</b>	<ol style="list-style-type: none"><li>1. FFT services cannot be provided at the same time as any out-of-home service, except in cases where the youth has a planned discharge from out-of-home care within thirty (30) days. FFT can work with the youth and family for up to thirty (30) days when the transition plan calls for FFT to aid in family reunification following residential care.</li><li>2. FFT services cannot overlap with any Intensive In-Home or Intensive Outpatient service.</li></ol>
<b>Clinical Exclusions</b>	<ol style="list-style-type: none"><li>1. Youth for whom a primary long-term caregiver cannot be identified despite extensive efforts to locate all extended family, adult friends, and other potential surrogate caregivers;</li><li>2. Youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior. Once stable, youth who otherwise meet the eligibility criteria may be referred for FFT services.</li></ol>

### Staffing Requirements:

In addition to the staffing requirement listed in the general standards, these staff requirements must also be followed. If the standards referenced here differ from those in the general standards, these staffing requirements will supersede the general standards.

1. FFT services must be provided by therapists who are CAMHD-credentialed MHPs.
2. Therapists must be supervised by an individual who is a CAMHD-credentialed QMHP. Supervisors must have training and experience in providing family therapy.
3. All therapists and supervisors must have specialized training in Functional Family Therapy.

### Clinical Operations:

In addition to the clinical operation requirements listed in the general standards, these requirements must also be followed. If the standards referenced here differ from those in the general standards, these clinical operation requirements will supersede the general standards.

1. Service delivery must be preceded by a thorough assessment of the youth and their family so that an appropriate and effective treatment plan can be developed.
2. Providers must have the ability to deliver services in a home setting; they may deliver some of the services for each youth and family in a clinic setting.
3. The agency has policies that govern the provision of services in natural settings and that document that the agency respects youths' and families' right to privacy and confidentiality when services are provided in these settings.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

4. Contractor must have a QMHP that oversees all program staff is and responsible for all clinical decisions made.
5. Staff must complete the required FFT training program from a licensed trainer of FFT services prior to assignment of families/clients. In addition, staff must attend quarterly booster training sessions.
6. Staff shall receive at a minimum one (1) hour of group supervision and one (1) hour of FFT services telephone consultation per week.
7. The agency has established procedures/protocols in place for managing crises effectively and efficiently through the direct interventions of its professional clinical and medical staff. Included in these procedures is the handling of emergency and crisis situations that describe methods for triaging youth who require more intensive interventions. Request for police/crisis hotline assistance are limited to situations of imminent risk or harm to self or others.
8. Upon receipt of the referral packet from the MHCC the agency offering FFT services will assign a therapist who must make face-to-face contact with the youth/family within seventy-two (72) hours or notify MHCC of reasons why contact could not be made.
9. Each provider has policies and procedures governing the provision of outreach services, including methods for protecting the safety of staff who engage in outreach activities.
10. These services include consultation with the youth, parents or other caregivers regarding behavior management skills, dealing with treatment responses of the individual and other caregivers and family members, and coordinating with other treatment providers.
11. Services are individually designed for each family, in full partnership with the family, to minimize intrusion and maximize independence. Services are normally more intensive at the beginning of treatment and decrease over time as the individual and/or family's strengths and coping skills develop.
12. FFT services must be flexible with the capacity to address concrete therapeutic and environmental issues in order to stabilize a crisis situation as soon as possible. Services are evidence-based, family-focused, active and rehabilitative, and delivered primarily in the individual's home or in a clinic. Services are initiated when there is a reasonable likelihood that such services will lead to specific, observable improvements in the youth and family's functioning.
13. The majority of services, sixty percent (60%) or more, are provided face-to-face with the youth and their families and eighty percent (80%) of all face-to-face services are delivered in non-clinic settings over the authorization period.
14. The agency must have an FFT organizational plan that addresses the following:
  - a. Description of the particular family preservation, coordination, crisis intervention and wraparound services models utilized, types of intervention practiced, and typical daily schedule for staff;
  - b. Description of the staffing pattern and how staff are deployed to ensure that the required staff-to-youth ratios are maintained, including how unplanned staff absences, illnesses, etc. are accommodated;
  - c. Description of the hours of operation, the staff assigned and types of services provided to youth, families, parents, and/or guardians; and
  - d. Description as to how the plan for services is modified or adjusted to meet the needs specified in each youth's individual plan.
15. The Contractor must do a Summary Annual Assessment for SEBD eligible youth in their care at the time the annual assessment is due on youth who have received at least three (3) months of services from the Contractor. See Summary Annual Assessment performance standards in Section II, Part D.
16. Please see Section I General Standards for additional clinical operation requirements:
  - D. Co-Occurring Disorders;
  - F. Referral Process for Services:
    - Referral Acceptance;

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

- G. CAMHD Continuity of Care;
- H. Staffing;
- I. Supervision;
- J. Evaluation of Staff Performance;
- K. Credentialing Requirements;
- N. Service Quality;
- O. Minimum Reporting Requirements;
- P. Risk Management:
  - Criminal, Child Abuse, and Background Screening;
  - Safety;
  - Restraints and Seclusion;
  - Sentinel Events and Incidents;
  - Police.

### Documentation

In addition to the documentation requirements listed in the general standards, these requirements must also be followed. If the standards referenced here differ from those in the general standards, these documentation requirements will supersede the general standards.

1. FFT therapists must complete an intake and assessment form upon assignment of youth/family to FFT services.
2. FFT therapists must complete “Case Consultation summary forms” weekly for case review during group supervision and FFT case consultation sessions.
3. FFT therapists must provide MHCC with a thirty (30) day written notice of intent to discontinue services.
4. FFT therapists must provide the MHCC with a copy of MHTP goals or overarching goals so the FGC has in the youth’s record what the provider goals are.
5. Please see Section I General Standards for additional documentation requirements:
  - E. Service Planning:
    - Mental Health Treatment Plan including transition, crisis and discharge planning;
    - Discharge Summary;
  - M. Maintenance of Service Records:
    - Progress Notes;
  - O. Minimum Reporting Requirements:
    - Monthly Treatment and Progress Summary.
6. Provider must complete all documentation requirements specific to FFT.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### K. PARENT SKILLS TRAINING

<b>Definition</b>	The teaching of evidenced base behavior management interventions to parents or caregivers in order to develop effective parenting styles. These interventions are designed to promote more competencies in the parent/caregiver's ability to manage the youth's behavior. The focus of training is on the parent and adjusting their responses to the youth. Parent Skills Training can occur in the home or community and be comprised of groups or individuals with or without the youth present. Parent Skills Training may be offered to the primary caregiver even if the youth is being served in an out-of-home service. In this case, the training is offered in anticipation of the youth's return.
<b>Services Components</b>	The core component of Parent Skills Training is intended to improve the parents' behavior management skills. Examples of such skills include: giving effective directives, the use of preventive and corrective teaching, using differential attention, teaching self-control, utilizing positive behavioral supports and effective praise, etc. Training is provided by parent educators (not necessarily therapists) and can utilize many teaching tools such as: skills manuals for parents, video taped modeling, homework assignments and didactic lessons.
<b>Admission Criteria</b>	<p><u>All</u> of the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. The identified youth meets SEBD Eligibility criteria for CAMHD (See Appendix B-7), is registered with a Branch and has an assigned MHCC;</li> <li>2. The CSP includes this service and measurable objectives for outcomes of this service prior to admission;</li> <li>3. Youth must be between the ages of three (3) and sixteen (16);</li> <li>4. The parent(s) need support in learning to respond to their child's behavior in a manner that promotes the child's ability more effectively regulate his/her emotions/behavior; and</li> <li>5. There must be a reasonable expectation that the parent(s) have the ability and motivation to initiate changes in their parenting style and can benefit from six to twelve (6 to 12) sessions;</li> </ol>
<b>Initial Authorizations</b>	<p>Authorization may be up to forty-eight (48) units for the month by the MHCC.</p> <p>Unit = fifteen (15) minutes</p>
<b>Re-Authorization</b>	<p>Reauthorization may be up to thirty-two (32) units per month with approval of the Clinical Director, Clinical Psychologist or MHS1.</p> <p>Unit = fifteen (15) minutes</p>
<b>Continuing Stay Criteria</b>	<u>One</u> (1) of the following criteria must be met as determined by

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	clinical review of service documentation, plan and progress: <ol style="list-style-type: none"><li>1. Parent has shown ability to grasp concepts and initiate changes in parenting style, but needs some additional assistance;</li><li>2. Parent has had absence from instruction due to health or unexpected childcare responsibilities, but is actively involved with treatment; or</li><li>3. Cognitive limitations of parent and/or literacy issues determine the need for repetitive learning and individualized instruction.</li></ol>
<b>Discharge Criteria</b>	The parent/caregiver is no longer in need of or eligible for services due to at least <u>one</u> (1) of the following: <ol style="list-style-type: none"><li>1. The youth/family is no longer eligible for SEBD services. As part of discharge, the MHCC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible; or</li><li>2. Completion of Parent Skills Training module.</li></ol>
<b>Service Exclusions</b>	<ol style="list-style-type: none"><li>1. Parent Skills Training is not a stand-alone service, but is part of a larger treatment plan and the young adult/youth and family are actively engaged in treatment.</li></ol>
<b>Clinical Exclusions</b>	<ol style="list-style-type: none"><li>1. Parents are unavailable to or unwilling to participate in or benefit from instruction.</li><li>2. Parent's mental disorder is significantly impeding instruction.</li><li>3. Parental substance abuse is rendering them unavailable to instruction.</li></ol>

### Staffing Requirements:

In addition to the staffing requirement listed in the general standards, these staff requirements must also be followed. If the standards referenced here differ from those in the general standards, these staffing requirements will supersede the general standards.

1. Parent Skills Training services shall be provided by personnel meeting one (1) of the following requirements:
  - a. Credentialed by CAMHD as a Qualified Mental Health Professional (QMHP);  
**OR**
  - b. A Parent Partner of HFAA Parent Partners working in frequent supervisory consultation with a credentialed QMHP from CAMHD;  
**OR**
  - c. Credentialed by CAMHD as a Mental Health Professional (MHP);  
**AND**
  - d. Working under the supervision of a QMHP above. The supervisor is expected to review all of the supervisees work in detail.
2. Providers are to follow all applicable professional practice standards and ethical guidelines.

### Clinical Operations

In addition to the clinical operation requirements listed in the general standards, these requirements must also be followed. If the standards referenced here differ from those in the general standards, these clinical operation requirements will supersede the general standards.

## **INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES**

---

1. Parent Skills Training program must be provided under the supervision and guidance of a QMHP.
2. Service must be preceded by an intake and assessment of the parent/caregiver(s) prior to the beginning of the skills training. This assessment will lead to matching of the parent/caregiver to group suited to their needs.
3. Provider is to follow all applicable professional practice standards and ethical guidelines.
4. Parent Trainer must receive at least twelve (12) hours of orientation utilizing an Evidenced Based operationalized Parent Training Approach.
4. Please see Section I General Standards for additional clinical operation requirements:
  - D. Co-Occurring Disorders;
  - F. Referral Process for Services:
    - Referral Acceptance;
  - G. CAMHD Continuity of Care;
  - H. Staffing;
  - I. Supervision;
  - J. Evaluation of Staff Performance;
  - K. Credentialing Requirements;
  - N. Service Quality;
  - O. Minimum Reporting Requirements;
  - P. Risk Management:
    - Criminal, Child Abuse, and Background Screening;
    - Safety;
    - Restraints and Seclusion;
    - Sentinel Events and Incidents;
    - Police.

### **Documentation**

1. Please see Section I General Standards for additional documentation requirements:
  - E. Service Planning:
    - Discharge Summary;
  - M. Maintenance of Service Records:
    - Progress Notes;
  - O. Minimum Reporting Requirements:
    - Monthly Treatment and Progress Summary.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### L. TREATMENT/SERVICE PLANNING PARTICIPATION

<b>Definition</b>	Treatment/service planning participation is the development, review, and modification of a MHTP, CSP, Crisis Plan, Discharge/Transition Plan, and other interagency treatment/service plans when specifically requested by the MHCC and is provided by a CAMHD Clinician.
<b>Services Components</b>	This service includes <u>all</u> of the following: <ol style="list-style-type: none"><li>1. Attendance and active participation at a multi-disciplinary treatment/service planning conference;</li><li>2. Providing an organized presentation of pertinent information related to mental health issues;</li><li>3. Participation in the formulation of plans for mental health services, including but not limited to the identification of goals, measurable objectives, and interventions based on young adult or youth/family needs;</li><li>4. Documented signature of attendance on treatment/service plan;</li><li>5. Progress note written and placed in young adult or youth's clinical record documenting the nature of the provider's participation in the meeting; and</li><li>6. Signed and dated copy of the treatment/service plan placed in the young adult or youth's clinical record.</li></ol>
<b>Admission Criteria</b>	<u>All</u> of the following criteria are met: <ol style="list-style-type: none"><li>1. The identified young adult or youth meets SEBD Eligibility criteria for CAMHD (See Appendix B-7), is registered with a Branch and has an assigned MHCC; and</li><li>2. The MHCC identifies that participation of the CAMHD clinician in the treatment/service planning conference would be clinically beneficial.</li></ol>
<b>Initial Authorizations</b>	Authorization for a CAMHD Clinician may not exceed eight (8) units by the MHCC.
<b>Discharge Criteria</b>	Completion of the treatment plan or participation no longer needed to complete plan.

#### Staffing Requirements

1. Treatment/service planning participation must be provided by personnel that meet one (1) of the following requirements:
  - a. CAMHD employee credentialed by as a Qualified Mental Health Professional (QMHP);  
**OR**
  - b. CAMHD employee credentialed by as a Mental Health Professional (MHP);  
**AND**
  - c. Working under the supervision of a QMHP above. The supervisor is expected to review all work in detail and to have ultimate responsibility for the supervisee's work.
2. Providers are to follow all applicable professional practice standards and ethical guidelines.

### Documentation

1. Progress note written and placed in young adult or youth's clinical record documenting the nature of the clinician's participation in the meeting.
2. Signed and dated copy of the treatment/service plan placed in the young adult or youth's clinical record.



## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### M. EDUCATIONAL PLANNING (IEP) PARTICIPATION

<b>Definition</b>	Attendance and active participation in multi-disciplinary educational planning meetings, including the development, review, and modification of an IEP, or other education related plan when specifically requested by the CAMHD MHCC and is provided by a CAMHD Clinician.
<b>Services Components</b>	This service includes <u>all</u> of the following: <ol style="list-style-type: none"><li>1. Attendance at a multi-disciplinary educational planning conference;</li><li>2. Providing an organized presentation of pertinent information related to mental health issues;</li><li>3. Participation in the formulation of plans for educationally-related mental health services, including but not limited to the identification of goals, measurable objectives, and interventions based on young adult or youth/family needs;</li><li>4. Documented signature of attendance on the education plan;</li><li>5. Progress note written and placed in young adult or youth's clinical record documenting nature of mental health related participation; and</li><li>6. Signed and dated copy of the education plan placed in the young adult or youth's clinical record.</li></ol>
<b>Admission Criteria</b>	<u>All</u> of the following criteria are met: <ol style="list-style-type: none"><li>1. The identified young adult or youth meets SEBD Eligibility criteria for CAMHD (See Appendix B-7), is registered with a Branch and has an assigned MHCC; and</li><li>2. The MHCC identifies that participation of the CAMHD clinician in the education planning conference would be clinically beneficial.</li></ol>
<b>Initial Authorizations</b>	Authorization for a CAMHD Clinician may not exceed eight (8) units by the MHCC.
<b>Discharge Criteria</b>	Participation at the educational planning meeting is concluded or the participation of the clinician is no longer needed to complete the educational plan.

#### Staffing Requirements:

1. IEP/MP educational planning participation must be provided by personnel that meet one (1) of the following requirements:
  - a. CAMHD employee credentialed by as a Qualified Mental Health Professional (QMHP);  
**OR**
  - b. CAMHD employee credentialed by as a Mental Health Professional (MHP);  
**AND**
  - c. Working under the supervision of a QMHP above. The supervisor is expected to review all work in detail and to have ultimate responsibility for the supervisee's work.

### Documentation

1. Progress note written and placed in young adult or youth's clinical record documenting the nature of the clinician's participation in the meeting.
2. Signed and dated copy of the IEP plan placed in the young adult or youth's clinical record.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### N. SCHOOL CONSULTATION

<b>Definition</b>	Consultation of a mental health professional with regular and special education teachers, school administrators and other school personnel regarding the behavioral management of a young adult or youth within the school setting. School consultation is authorized by the MHCC when requested by or agreed upon by the school, in collaboration with the young adult or youth's team. This service is provided by a CAMHD Clinician.
<b>Services Components</b>	<ol style="list-style-type: none"><li>1. School consultation is a collaborative process, which serves to improve the link between a young adult or youth's MHTP and his/her IEP. School consultation provides additional clinical support to help the school maintain a young adult or youth in the most natural, least restrictive school program that is able to meet the young adult or youth's needs;</li><li>2. School consultation facilitates communication between school personnel and mental health providers, between home and school, as well as between various school staff, such as between regular and special educators. While the focus of consultation is on behavioral management issues, it can include organizational management of the classroom (e.g., seating arrangements, and scheduling) to boost the efficacy of inclusion of children with disabilities;</li><li>3. The mental health professional can provide general and intervention-specific information on particular mental health diagnoses (e.g., Attention-Deficit/Hyperactivity Disorder, Tourette Disorder) as well as certain mental health variables (e.g., emotional dysregulation, poor achievement motivation, lack of social skills) and their potential impact on classroom performance;</li><li>4. School consultation generally includes a face-to-face contact by the mental health professional with a teacher, administrator or other school personnel for the purpose of sharing information and facilitating communication. The contact may be made by phone if the school visitation is not feasible and the goals of that consultation can be accomplished long-distance (e.g., helping a teacher fine-tune a behavior management plan);</li><li>5. The following responsibilities of the school consultant are important to insure collaboration and efficacy:<ol style="list-style-type: none"><li>a. Obtain parental consent to visit the school and share information with school personnel;</li><li>b. Access and review pertinent educational and mental health data available in the young adult or youth's clinical record;</li><li>c. Adhere to school protocols regarding rules and responsibilities on school campus;</li><li>d. Conduct classroom observation(s), if needed, to witness young adult or youth's functioning in the school setting; and</li></ol></li></ol>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<ul style="list-style-type: none"><li>e. Hold consultation meeting(s) with appropriate school personnel to discuss specific issues/interventions related to the young adult or youth's school performance, to provide specific recommendations, and to follow-up on the results of recommendations;</li><li>6. Complete a progress note within twenty-four (24) hours of any contact; and</li><li>7. A summary report of finding and recommendation is submitted to the appropriate school personnel as well as the MHCC.</li></ul>
<b>Admission Criteria</b>	<p><u>All</u> of the following criteria are met:</p> <ul style="list-style-type: none"><li>1. The identified young adult or youth meets SEBD Eligibility criteria for CAMHD (See Appendix B-7), is registered with a Branch and has an assigned MHCC;</li><li>2. The MHCC, in collaboration with the young adult or youth's treatment team, decides that delivery of school consultation by a CAMHD clinician would be clinically beneficial and the school agrees to the service; and</li><li>3. Appropriate school personnel request the delivery of school consultation by the CAMHD clinician and the Mental Health Care Coordinator agrees.</li></ul>
<b>Initial Authorizations</b>	<p>Authorization for a CAMHD clinician may not exceed eight (8) units by the MHCC.</p> <p>However, an additional unit will be allowed if classroom observations are conducted.</p>
<b>Discharge Criteria</b>	<p>A consultation report is completed and placed in the young adult or youth's clinical record, reflecting issues and treatment strategies discussed.</p>

### Staffing Requirements

1. Whenever possible, school consultation services shall be provided by a mental health professional who is familiar with the young adult or youth and the young adult or youth's family. In addition to having training and/or experience with behavioral management strategies and interfacing with schools, personnel must meet one (1) of the following requirements:
  - a. CAMHD employee credentialed by as a Qualified Mental Health Professional (QMHP);
  - OR**
  - b. CAMHD employee credentialed by as a Mental Health Professional (MHP);
  - AND**
  - c. Working under the supervision of a QMHP above. The supervisor is expected to review all of the supervisees work in detail, and to have full responsibility for the work.

### Documentation

1. Progress note written and placed in young adult or youth's clinical record documenting the nature of the provider's consultation activities.

2. A summary report is completed, sent to the MHCC, and placed in the young adult or youth's clinical record, reflecting issues and behavior management strategies discussed, as well as school personnel's receptivity to the consultation intervention within two weeks of service.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### O. CASE CONSULTATION

<b>Definition</b>	Consultation by a mental health professional who has a particular area of expertise. The MHCC authorizes case consultation when requested by or agreed upon by the young adult or youth's clinical treatment team. This is provided by a CAMHD clinician.
<b>Services Components</b>	<ol style="list-style-type: none"> <li>1. Case consultation provides additional clinical support to help a young adult or youth's CSP/MHTP) team provide appropriate treatment to a young adult or youth and his or her family. Case consultation may help the team: develop a clear and useful clinical formulation of the young adult or youth's difficulties, obtain the evidence-based treatment interventions that are most likely to be effective, or develop a comprehensive plan to serve the young adult or youth in the most natural, least restrictive treatment setting (i.e. prevent movement to a higher level of care, step-down from a hospital level of care, facilitate successful family reunification, etc.);</li> <li>2. Case consultation facilitates communication among members of the multi-disciplinary treatment team and helps team members develop a shared understanding of the young adult or youth and his/her family, the challenges they face, and the long-term plan for helping them function independently of CAMHD services;</li> <li>3. The case consultant can provide general and intervention-specific information on particular mental health diagnoses (e.g., Attention-Deficit/Hyperactivity Disorder, Tourette Disorder) as well as certain mental health variables (e.g., emotional dysregulation, poor achievement motivation, lack of social skills) and their potential impact on the young adult or youth's functioning;</li> <li>4. The case consultant can provide information about a specialized, psychosocial or psychopharmacological evidence-based treatment approach and how it might be implemented in a specific young adult or youth's case;</li> <li>5. The case consultant can review the behavior management plan being used with a young adult or youth in a treatment setting and make recommendations for improving it;</li> <li>6. Case consultation generally includes a face-to-face contact by the mental health professional with members of the team for the purpose of sharing information and facilitating communication. The contact may, however, be made by phone if a face-to-face meeting is not feasible and the goals of the consultation can be accomplished long-distance (e.g., helping the team locate a therapist who can provide a specific evidence-based service);</li> <li>7. The following responsibilities of the case consultant are important to ensure collaboration and efficacy: <ol style="list-style-type: none"> <li>a. Access and review pertinent mental health data available in the young adult or youth's clinical record;</li> </ol> </li> </ol>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<ul style="list-style-type: none"><li>b. Discuss the team's concerns and how they can be addressed with the MHCC and/or other members of the young adult or youth's team;</li><li>c. Hold consultation meeting(s) with appropriate clinical personnel or other team members to discuss specific issues/interventions related to the young adult or youth's treatment, to provide specific recommendations and to follow-up on the results of recommendations with written consultation summary report; and</li><li>d. Complete a progress note within twenty-four (24) hours of any contact.</li></ul>
<b>Admission Criteria</b>	<p><u>All</u> of the following criteria are met:</p> <ul style="list-style-type: none"><li>1. The identified young adult or youth meets SEBD Eligibility criteria for CAMHD (See Appendix B-7), is registered with a Branch and has an assigned MHCC; and</li><li>2. The MHCC, in collaboration with the young adult or youth's treatment team, decides that Case Consultation by a CAMHD clinician would be clinically beneficial.</li></ul>
<b>Initial Authorizations</b>	<p>Authorization for a CAMHD clinician may not exceed eight (8) units by the MHCC.</p> <p>Unit = fifteen (15) minutes</p>
<b>Discharge Criteria</b>	<p>A consultation report is completed and placed in the young adult or youth's clinical record, reflecting issues and treatment strategies discussed.</p>

### Staffing Requirements:

1. Case consultation services shall be provided by a mental health professional who can provide specialized expertise in a clinical area that is relevant to the needs of the young adult or youth and/or the young adult or youth's family. In addition to having training and/or experience with behavioral management strategies and mental health treatment, personnel must meet one (1) of the following requirements:
  - a. CAMHD employee credentialed by as a Qualified Mental Health Professional (QMHP);  
**OR**
  - b. CAMHD employee credentialed by as a Mental Health Professional (MHP);  
**AND**
  - c. Working under the supervision of a QMHP, as above. The supervisor is expected to review all of the supervisees work in detail, and to have full responsibility for the work.

### Documentation

1. Progress note written and placed in young adult or youth's clinical record within twenty-four (24) hours of service documenting the nature of the provider's consultation activities.

## **INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES**

---

2. A consultation report is completed, sent to the MHCC, and placed in the young adult or youth's clinical record, reflecting issues and behavior management strategies discussed, as well as treatment team's receptivity to the consultation intervention within two (2) weeks of service.



## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### P. FAMILY COURT TESTIMONY

<b>Definition</b>	Participation in a State of Hawaii Family Court hearing at the may include, but is not be limited to, sharing information about the young adult or youth's psychosocial history, diagnostic assessment and formulation, treatment planning/recommendations, and therapeutic progress. Participation can include oral testimony and/or the preparation of a written report. This participation is intended to ensure that the court has access to all relevant information needed for proper decision-making and is authorized by the MHCC and is provided by a CAMHD clinician.
<b>Services Components</b>	<ol style="list-style-type: none"> <li>1. Attend the Family Court hearing to give oral testimony, as requested by the MHCC to present relevant information for the court's consideration;</li> <li>2. Court report writing by the clinician as needed for the court hearing. Note: Monthly Progress and Summary reports, provider's progress notes, clinical evaluations, other existing reports do not suffice;</li> <li>3. Reports shall be made available to the MHCC for review twelve (12) working days prior to the court hearing; and</li> <li>4. Whether written or oral testimony clinical recommendations are to be based on the presenting needs of the young adult or youth and family, and are consistent with the Hawaii CASSP principles. Recommendations shall reflect structure and supports young adult or youth needs rather than specify specific services (i.e., young adult or youth requires day treatment services).</li> </ol>
<b>Admission Criteria</b>	<p><u>All</u> of the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. The identified young adult or youth meets SEBD Eligibility criteria for CAMHD (See Appendix B-7), is registered with a Branch and has an assigned MHCC;</li> <li>2. Young adult or youth has a scheduled court hearing; and</li> <li>3. The MHS1 and MHCC identifies that participation by a CAMHD clinician would be helpful to the court in understanding the young adult or youth's case.</li> </ol>
<b>Initial Authorizations</b>	<p>Authorization for a CAMHD clinician may not exceed eight (8) units by the MHCC.</p> <p>Unit = fifteen (15) minutes</p>
<b>Discharge Criteria</b>	This service delivery ends at the completion of the court hearing for the scheduled day, or when the MHCC/MHS1 accepts the requested court report.

#### Staffing Requirements:

1. Whenever possible, court testimony services shall be provided by a mental health professional who is familiar with the young adult or youth and the young adult or youth's family. In addition to

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

having training and/or experience with behavioral management strategies, personnel must meet one (1) of the following requirements:

a. CAMHD employee credentialed by as a Qualified Mental Health Professional (QMHP);

**OR**

b. CAMHD employee credentialed by as a Mental Health Professional (MHP);

**AND**

c. Working under the supervision of a QMHP above. The supervisor is expected to review all of the supervisees work in detail, and to have full responsibility for the work.

### **Documentation**

1. Progress note written and placed in young adult or youth's clinical record documenting the nature of the clinician's testimony activities.
2. If testimony is written, then a court report is sent to the MHCC twelve (12) working day prior to court hearing and placed in the young adult or youth's clinical record, reflecting issues and behavior management strategies recommended.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### Q. INTENSIVE OUTPATIENT TREATMENT FOR CO-OCCURRING SUBSTANCE ABUSE

<b>Definition</b>	Intensive outpatient substance abuse treatment service is defined as a package of services designed to assist youth and young adults who have co-occurring mental health and substance abuse issues. The service addresses both the youth's substance abuse treatment while stabilizing the mental health condition. This treatment allows youth to remain at home in their natural environment while being treated. These services are provided during the day and evening hours to enable the individual to maintain residence in the community, continue to work or go to school, and be part of their family/community life.
<b>Services Offered</b>	<ol style="list-style-type: none"> <li>1. Intake process that includes: substance use assessment, orientation to program components, requirements and limits of confidentiality, and treatment planning;</li> <li>2. Social detoxification and/or referral for clinically managed or medical detoxification as needed;</li> <li>3. Group counseling provides support, chemical dependency education classes, anger management and conflict resolution, communication, understanding family patterns, problem-solving, tobacco cessation, healthy leisure activities, and risk/harm reduction and are offered each day the program is in operation;</li> <li>4. The program provides Family Therapy* as indicated in youth's plan;</li> <li>5. Individual Therapy* focused on evidenced- based approaches to treating both the mental health disorder and substance abuse;</li> <li>6. Relapse prevention planning to include community and social support systems in treatment process.</li> <li>7. Crisis contingency planning;</li> <li>8. Disease management;</li> <li>9. Case Management services for linkages and referral to community resources; supports such as self-help groups offering positive role models, 12-step groups, Rational Recovery model, or other supports;</li> <li>10. Routine and random urinalysis (UAs);</li> <li>11. Consultation with psychiatrist or other professionals, are available within twenty (24) hours by telephone and within seventy-two (72) hours face-to-face (depending on the urgency of the situation) through on-site services, referral to off-site services, or transfer to another level of care; and</li> <li>12. Emergency services, which are available by telephone twenty-four (24) hours a day when the program is not in session;</li> </ol>
<b>Admission Criteria</b>	<p><u>All</u> of the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. The identified young adult or youth meets SEBD Eligibility</li> </ol>

\*See performance standard for service referenced.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p>criteria for CAMHD (See Appendix B-7), is registered with a Branch and has an assigned MHCC;</p> <ol style="list-style-type: none"> <li>The young adult or youth must be between the ages of eleven (11) and twenty-one (21);</li> <li>Young adult or youth must be identified in the CSP as needing outpatient substance abuse treatment services due to an Axis I substance abuse disorder;</li> <li>There must be a reasonable expectation that the young adult or youth and/or the family will benefit from outpatient treatment services within four (4) months;</li> <li>Measurable treatment goals are identified in the young adult or youth's Coordinated Service Plan prior to admission; and</li> <li>The young adult or youth and/or family are amenable to actively working with treatment staff for the duration of the treatment period.</li> </ol>
<b>Initial Authorizations</b>	<p>Authorization may be up to:</p> <p>Maximum of sixteen (16) units per day</p> <p>Maximum of forty-eight (48) units per week</p> <p>Maximum of two (2) months as authorized by the MHCC.</p> <p>Unit = fifteen (15) minutes</p>
<b>Re-Authorization</b>	<p>Reauthorization with approval from the MHS1 may be up to:</p> <ul style="list-style-type: none"> <li>Third month: <ul style="list-style-type: none"> <li>Maximum of eight (8) units per day</li> <li>Maximum of twenty four (24) units per week</li> </ul> </li> <li>Fourth month: <ul style="list-style-type: none"> <li>Maximum of four (4) units per day</li> <li>Maximum of twelve (12) units per week</li> </ul> </li> </ul> <p>Any re-authorization request that exceed the four (4) months maximum or this titration must be approved by the Clinical Psychologist.</p> <p>Unit = Fifteen (15) minutes</p>
<b>Continuing Stay Criteria</b>	<p><u>All</u> of the following criteria must be met as determined by review of service documentation, plans and progress:</p> <ol style="list-style-type: none"> <li>There are regular and timely assessments and documentation of young adult or youth's response to interventions. Timely and appropriate modifications to the MHTP are made that are consistent with the young adult or youth's status;</li> <li>A discharge plan is formulated and regularly reviewed, revised, and appropriately implemented in a timely manner, identifies specific discharge criteria to be met, and includes specific target dates for reaching each goal;</li> <li>Young adult or youth has relapse (s) behavior that needs further addressing; or</li> </ol>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<ol style="list-style-type: none"> <li>There is a reasonable expectation that the young adult or youth will make progress in reaching or maintaining abstinence within eight (8) weeks.</li> </ol>
<b>Discharge Criteria</b>	<p>Young adult or youth is no longer in need of or eligible for services due to at least <u>one</u> (1) of the following:</p> <ol style="list-style-type: none"> <li>Completion of the individual goals and referral to community resources for follow up;</li> <li>The young adult or youth/family requests discharge/withdraw consent for treatment with no imminent danger to self or others;</li> <li>Young adult or youth has demonstrated minimal or no progress toward treatment goals for a two (2) month period and appropriate modifications of the MHTP has been made and implemented with no significant success and the CSP team determines that the youth is not benefiting from this services at this time; or</li> <li>The young adult or youth is no longer eligible for SEBD services. As part of discharge, the MHCC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible.</li> </ol>
<b>Service Exclusions</b>	<ol style="list-style-type: none"> <li>Not offered at the same time as any out-of home service.</li> <li>Not offered at the same time as Intensive In-Home Intervention, Multisystemic Therapy, Functional Family Therapy, or Intensive Outpatient Independent Living Skills program, except when the youth has a planned discharge from this within two (2) weeks of referral.</li> </ol>
<b>Clinical Exclusions</b>	<ol style="list-style-type: none"> <li>Young adult or youth in need of clinically managed detoxification or medical detoxification.</li> <li>Young adult or youth in need of immediate crisis stabilization because of active suicidal, homicidal or psychotic behavior. Once stable young adult or youth who otherwise meet the eligibility criteria may be referred into this service.</li> </ol>

### Staffing Requirements:

In addition to the staffing requirement listed in the general standards, these staff requirements must also be followed. If the standards referenced here differ from those in the general standards, these staffing requirements will supersede the general standards.

- Program is staffed by an interdisciplinary team of appropriately trained clinicians who assess and treat the youth or young adult's substance-related and co-occurring psychiatric disorders. One or more professional addiction clinicians (CSAC) is on-site during the program hours.
- The maximum face-to-face staff to client ratio is not more than one to eight (1:8).
- The program and staff must be under the clinical supervision of a QMHP.
- At least one (1) CSAC must be on staff to review, develop and approve the psycho educational curriculum.
- All groups will be no larger than twelve (12) with a QMHP present.
- The program staff psychiatrist or consultant is available for medical emergencies, assessments, and consultation. The psychiatrist is onsite for those emergencies that merit face-to-face services within one (1) hour of the call for assistance and makes direct arrangements with a community

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

hospital in the event the youth is in need of possible hospitalization. This will be duly documented and kept on file at the program. There is established protocol for appropriate qualified medical coverage in the absence of the designated psychiatrist. The psychiatrist has courtesy privileges at the community hospital within the same county as the program.

### **Clinical Operations**

In addition to the clinical operation requirements listed in the general standards, these requirements must also be followed. If the standards referenced here differ from those in the general standards, these clinical operation requirements will supersede the general standards.

1. Service delivery must be preceded by a thorough assessment of the young adult or youth and their family so that an appropriate and effective treatment plan can be developed. A complete Intake, Screening, and Assessment are provided to each young adult or youth prior to or upon admission.
2. Provider is to follow all applicable professional practice standards and ethical guidelines.
3. The agency has established procedures/protocols in place for managing crises and effectively and efficiently through the direct interventions of its professional clinical and medical staff. Included in these procedures is the handling emergency and crisis situations that describe methods for triaging young adult or youth who require more intensive interventions. Request for police/hotline assistance are limited to situations of imminent risk of harm to self or others.
4. The young adult or youths' records must adhere to Federal law, State statutes, accreditation and Medicaid standards. Service records must be current, well-organized, legible, comprehensive and consisting of all relevant documentation for the optimum treatment of young adult or youth served.
5. Program must have twenty-four (24) hour a day seven (7) days a week emergency coverage when the program is not in operation. There must be an established means of coverage and client's having access to contact number.
6. The Contractor must do a Summary Annual Assessment for SEBD eligible youth in their care at the time the annual assessment is due on youth who have received at least three (3) months of services from the Contractor. See Summary Annual Assessment performance standards in Section II, Part D.
7. Please see Section I General Standards for additional clinical operation requirements:
  - D. Co-Occurring Disorders;
  - F. Referral Process for Services:
    - Referral Acceptance;
  - G. CAMHD Continuity of Care;
  - H. Staffing;
  - I. Supervision;
  - J. Evaluation of Staff Performance;
  - K. Credentialing Requirements;
  - N. Service Quality;
  - O. Minimum Reporting Requirements;
  - P. Risk Management:
    - Criminal, Child Abuse, and Background Screening;
    - Safety;
    - Restraints and Seclusion;
    - Sentinel Events and Incidents;
    - Police.

### Documentation

In addition to the documentation requirements listed in the general standards, these requirements must also be followed. If the standards referenced here differ from those in the general standards, these documentation requirements will supersede the general standards.

1. Please see Section I General Standards for additional documentation requirements:
  - E. Service Planning:
    - Mental Health Treatment Plan including transition, crisis and discharge planning;
    - Discharge Summary;
  - M. Maintenance of Service Records:
    - Progress Notes;
  - O. Minimum Reporting Requirements:
    - Monthly Treatment and Progress Summary

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

### R. INTENSIVE OUTPATIENT SERVICES FOR INDEPENDENT LIVING SKILLS

<b>Definition</b>	<p>A comprehensive treatment service provided to older adolescents and young adults who need to work intensively on developing a range of skills to prepare for independent living. The youth or young adults remain at home while attending the program. This service focuses on developing skills and resources related to life in the community and to increasing the participant's ability to live as independently as possible, to manage their illness and their lives with as little professional intervention as possible, and to participate in community opportunities related to functional, social, educational, and vocational. The amount of time any individual spends in these services will vary, depending on the individual needs. Generally, participation will be more intensive at the beginning of the program and the time spent in the program will decrease as new skills are attained.</p>
<b>Services Offered</b>	<p>The core components of an intensive outpatient program for young adults and youth with emotional and behavioral challenges who need to develop independent living skills include the following.</p> <ol style="list-style-type: none"><li>1. An intake and assessment process:<ol style="list-style-type: none"><li>a. Independent living and vocational skills assessment;</li><li>b. Assessment of individual and family needs;</li><li>c. Orientation to program components, requirements and limits of confidentiality, and</li><li>d. Treatment planning that includes helping the young adult/youth play a central role in decisions about treatment.</li></ol></li><li>2. An intensive specialized transition component:<ol style="list-style-type: none"><li>a. Each young young/adult in the program has an assigned Transition Facilitator who meets with him/her regularly and also engages his/her family as appropriate;</li><li>b. Assistance is provided with accessing needed financial assistance and benefits (e.g. applying for Social Security Disability benefits, obtaining housing subsidies, etc.);</li><li>c. Assistance is provided with obtaining appropriate services (e.g. vocational rehabilitation services; adult mental health services); and</li><li>d. Assistance is provided with obtaining support with any legal concerns (e.g. guardianship issues).</li></ol></li><li>3. Skills training interventions will be provided based on the initial and on-going assessment of the individual's needs. These may utilize an individual or group format. However, care is taken to group minors together separately from any young adults in the program. The program will provide access to work on skills in at least the following areas:<ol style="list-style-type: none"><li>a. Social skills, including communication and problem-solving in personal relationships;</li><li>b. Emotion regulation skills, including anger control and conflict management;</li><li>c. Self-care skills (i.e. cooking, laundry, house-cleaning, personal hygiene);</li></ol></li></ol>



## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<ul style="list-style-type: none"> <li>d. Basic personal finances (i.e. developing a budget, balancing a checkbook; utilizing credit);</li> <li>e. Developing life goals and planning for the future, including career planning;</li> <li>f. Understanding and taking charge of your own mental health treatment;</li> <li>g. Taking charge of your own physical health including nutrition, healthy lifestyles, smoking cessation, and sexual and reproductive health;</li> <li>h. Chemical dependency education; and</li> <li>i. Parenting skills training.</li> </ul> <p>4. Assistance developing vocational skills is provided in a practical, hands-on way, including one-on-one help by a vocational specialist who can assist with:</p> <ul style="list-style-type: none"> <li>a. Investigating fields and jobs that might be of interest;</li> <li>b. Doing volunteer work in areas consistent with career goals;</li> <li>c. Assessing one's own job-relevant skills and writing a resume;</li> <li>d. Obtaining job applications and interviewing for jobs;</li> <li>e. Finding sources of needed job training, including assistance working with DOE programs, vocation rehab programs, community college programs, GED programs, etc.; and</li> <li>f. Coaching and support to help the young adult/youth stick with challenging training and job experiences.</li> </ul> <p>5. Specific efforts to engage and support parents and other family members with the challenges of parenting a young person through the transition from adolescence to adulthood are part of the program. Specific services may include:</p> <ul style="list-style-type: none"> <li>a. Support groups for parents of young people in the program;</li> <li>b. Inclusion of parents in some group or individual sessions with the young people;</li> <li>c. Educational programs for parents about concerns such as benefits, changes in confidentiality requirements, guardianship options, etc.; and</li> <li>d. Family therapy interventions (biological and/or foster).</li> </ul> <p>6. Individual Therapy focused on mental health challenges utilizing evidenced-based approaches; and</p> <p>7. Consultation with a psychiatrist or other professionals, when needed.</p>
<b>Admission Criteria</b>	<p><u>All</u> of the following criteria are met:</p> <ul style="list-style-type: none"> <li>1. The identified young adult or youth meets SEBD Eligibility criteria for CAMHD (See Appendix B-7), is registered with a Branch and has an assigned MHCC;</li> <li>2. The youth must be sixteen (16) to twenty one (21) years of age;</li> <li>3. Young adult/youth must be identified as needing intensive outpatient services focused on promoting growth toward independent living with measurable treatment goals identified</li> </ul>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p>in the CSP prior to admission;</p> <ol style="list-style-type: none"> <li>4. There must be a reasonable expectation that the young adult/youth can benefit from intensive outpatient treatment services within the period of three (3) to six (6) months; and</li> <li>5. The youth adult/youth and/or family are amenable to actively working with program staff for the duration of the expected program period.</li> </ol>
<b>Initial Authorizations</b>	<p>Maximum of sixteen (16) units per day  Maximum of eighty (80) units per week  Maximum of four (4) weeks in duration  May be authorized by the MHCC</p> <p>Unit = fifteen (15) minutes</p>
<b>Re-Authorization</b>	<p>Re-authorizations with approved by the MHS1.</p> <ul style="list-style-type: none"> <li>• Second month: <ul style="list-style-type: none"> <li>• Maximum of eight (8) units per day</li> <li>• Maximum of forty (40) units per week</li> </ul> </li> <li>• Third month: <ul style="list-style-type: none"> <li>• Maximum of four (4) units per day</li> <li>• Maximum of twenty (20) units per week</li> </ul> </li> <li>• Fourth month: <ul style="list-style-type: none"> <li>• Maximum of four (4) units per day</li> <li>• Maximum of twenty (20) units per week</li> </ul> </li> <li>• Fifth month: <ul style="list-style-type: none"> <li>• Maximum of four (4) units per day</li> <li>• Maximum of twenty (20) units per week</li> </ul> </li> <li>• Sixth month: <ul style="list-style-type: none"> <li>• Maximum of four (4) units per day</li> <li>• Maximum of twenty (20) units per week</li> </ul> </li> </ul> <p>Any request for re-authorizations that exceed the six (6) months maximum or this titration must be approved by the Clinical Psychologist.</p> <p>Unit = 15 minutes</p>
<b>Continuing Stay Criteria</b>	<p><u>All</u> of the following criteria are met as determined by treatment team:</p> <ol style="list-style-type: none"> <li>1. There are regular and timely assessments and documentation of youth/family response to services. Timely and appropriate modifications are made to services and plan as needed;</li> <li>2. The young adult/youth continues to have specific needs that indicate that this is the most appropriate means of addressing those needs;</li> </ol>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<ol style="list-style-type: none"> <li>3. The young adult/youth continue to be actively involved in treatment interventions and treatment planning;</li> <li>4. Young adult/youth continues to have deficits in several areas of skills necessary for independent living;</li> <li>5. There is a reasonable expectation that the young adult/youth will continue to make progress toward reaching the goals and objectives identified in the MHTP and CSP within the next (4) weeks; or</li> <li>6. Young adult/youth continues to need intensive support in order to maintain newly acquired skills.</li> </ol>
<b>Discharge Criteria</b>	<p><u>One</u> (1) of the following must be met:</p> <ol style="list-style-type: none"> <li>1. The young adult/youth is no longer eligible for SEBD services. As part of discharge, the MHCC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible;</li> <li>2. The young adult/youth and family no longer wants to participate in this service and revokes consent with no imminent danger to self or others;</li> <li>3. Young adult/youth has demonstrated minimal or no progress toward treatment goals for a two (2) month period and appropriate modifications of MHTP has been made and implemented with no significant success and the CSP team determines that the young adult/youth is not benefiting from this services at this time;</li> <li>4. Young adult/youth exhibits new symptoms and/or behaviors challenges which cannot be safely and effectively address through this service;</li> <li>5. The young adult/young person reaches a level of functioning that allows for transition to independent living; or</li> <li>6. The young adult/youth has attained the knowledge and supports necessary to sustain treatment outcomes and/or to support a successful transition to live in the community.</li> </ol>
<b>Service Exclusions</b>	<ol style="list-style-type: none"> <li>1. Not offered at the same time as any out-of-home service, unless the young adult/youth is expected to be discharged from the other service within thirty (30) days of referral.</li> <li>2. Not offered at the same time as Intensive In-Home Intervention, Multisystemic Therapy, Functional Family Therapy, or Intensive Outpatient Treatment for Co-Occurring Substance Abuse program, except when the young adult/youth has a planned discharge from this within two (2) weeks of referral.</li> </ol>
<b>Clinical Exclusions</b>	<p>Youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior. Once stable, youth who otherwise meet the eligibility criteria may be referred into the program.</p>

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

### Staffing Requirements:

In addition to the staffing requirement listed in the general standards, these staff requirements must also be followed. If the standards referenced here differ from those in the general standards, these staffing requirements will supersede the general standards.

1. Staffing for adolescent outpatient treatment programs includes delineation of core staff and their essential roles such as counselors, transition facilitator, vocational specialists and paraprofessionals.
2. Program staff must include at least one (1) QMHP who can provide clinical supervision, program oversight, and active guidance to all other staff.
3. The program provides a Transition Facilitator that is assigned to each youth enrolled the program.
4. The QMHP develops or supervised the development of the MHTP.
5. The Transition Facilitator works with the youth to develop a Transition Support Plan (TSP) that outlines measurable independent living goals and objectives to be achieved in the program and incorporated into the MHTP.
6. Transition Facilitators must, at minimum, be a MHP.
7. The program is required to have a psychiatrist or psychologist provides twenty-four (24) hours on-call coverage, seven (7) days a week.
8. The ratio shall not exceed twelve (12), youth/young adult per primary Transition Facilitator (team leader) at any time with the consideration that at least two (2) of the twelve (12) youth/young adults will be stepping down to a less intensive level of care. Staff to client ratio takes into consideration evening and weekend hours, needs of special populations, and geographical areas to be covered.

### Clinical Operations

In addition to the clinical operation requirements listed in the general standards, these requirements must also be followed. If the standards referenced here differ from those in the general standards, these clinical operation requirements will supersede the general standards.

1. A complete Intake assessment is provided focusing on the young person's needs in the areas of independent living skills. Intake assessments may be completed by one individual or by a multidisciplinary team, but a QMHP must be involved to assure adequate integration of available clinical information into treatment planning.
2. Program has an intake process that includes integration of information available on youth/family in the treatment planning to ensure appropriate and effective treatment. Program also has an established protocol for orienting youth to the program.
3. The Contractor has established procedures/protocols in place for managing crises effectively and efficiently through the direct interventions of its professional clinical and medical staff. Included in these procedures is the handling of emergency and crisis situations that describe methods for triaging youth who require more intensive interventions. Request for police /crisis hotline assistance are limited to situations of imminent risk or harm to self or others.
4. Service delivery must be preceded by a thorough assessment of the youth and their family so that an appropriate and effective treatment plan can be developed.
5. The Contractor has established procedures/protocols for handling emergency and crisis situations that describe methods for triaging youth who require psychiatric hospitalization.
6. A QMHP experienced in evidenced-based treatment supervises treatment program.
7. The Contractor must do a Summary Annual Assessment for SEBD eligible youth in their care at the time the annual assessment is due on youth who have received at least three (3) months of services from the Contractor. See Summary Annual Assessment performance standards in Section II, Part D.
8. Please see Section I General Standards for additional clinical operation requirements:
  - D. Co-Occurring Disorders;
  - F. Referral Process for Services:

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

- Referral Acceptance;
- G. CAMHD Continuity of Care;
- H. Staffing;
- I. Supervision;
- J. Evaluation of Staff Performance;
- K. Credentialing Requirements;
- N. Service Quality;
- O. Minimum Reporting Requirements;
- P. Risk Management:
  - Criminal, Child Abuse, and Background Screening;
  - Safety;
  - Restraints and Seclusion;
  - Sentinel Events and Incidents;
  - Police.

### Documentation

In addition to the documentation requirements listed in the general standards, these requirements must also be followed. If the standards referenced here differ from those in the general standards, these documentation requirements will supersede the general standards.

1. Please see Section I General Standards for additional documentation requirements:
  - E. Service Planning:
    - Mental Health Treatment Plan including transition, crisis and discharge planning;
    - Discharge Summary;
  - M. Maintenance of Service Records:
    - Progress Notes;
  - O. Minimum Reporting Requirements:
    - Monthly Treatment and Progress Summary.
2. TSP must be written by the Transition Facilitator within two week of admission to the program. The TSP must cover the how the youth will be supported in developing their own goal around: Housing, Employment, Education, Social, Financial, and Health domains.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### S. COMMUNITY-BASED CLINICAL DETOXIFICATION

<b>Definition</b>	<p>A short-term, detoxification service delivered with medical and nursing support. This twenty-four (24) hour clinically managed detoxification is supervised by trained staff who observe and support the youth undergoing withdrawal in a <u>locked</u> residential facility. The program is designed to provide clinically managed detoxification services while keeping the co-occurring mental health disorder stabilized.</p> <p>Detoxification is designed to alleviate the short-term symptoms of withdrawal while the body's physiology is adjusting to the absences of drug and alcohol. It must also include a period of psychological readjustment designed to prepare the youth to take the next step in ongoing treatment. Detoxification process is expected to take no more than one (1) month.</p>
<b>Services Offered</b>	<ol style="list-style-type: none"> <li>1. Intake process that includes: substance use assessment, orientation to program components, requirements and limits of confidentiality, and treatment planning.</li> <li>2. Evidence-based treatment interventions in a structured therapeutic milieu in which behavior modification techniques are used to foster group living skills and an atmosphere of individual participation in a community of recovery</li> <li>3. Clinically managed detoxification services focused on safely transitioning youth to lower level of care.</li> <li>4. Opportunities for the youth to engage in age-appropriate structured culturally relevant recreational activities.</li> <li>5. Planned clinical program activities that are designed to develop and apply recovery skills (including relapse preventions), promote development of a social network supportive of recovery, reinforce prosocial values, enhance adolescent's understanding of addiction, promote successful involvement in regular, productive daily activities, enhance personal responsibility and developmental maturity and, promote successful reintegration into community living;</li> <li>6. Individual Therapy at least one (1) time per week to address identified issues*.</li> <li>7. Group Therapy* at least one (1) time per week to address identified issues, unless clinically contraindicated.</li> <li>8. Family Therapy* at least two (2) times per month that includes chemical dependency education as indicated in the youth plan.</li> <li>9. Medication administration and monitoring.</li> <li>10. Availability of emergency consultation with an ABPN child and adolescent psychiatrist (by telephone or in person).</li> <li>11. Availability of specialized clinical consultation and supervision for biomedical and emotional/behavioral problems related to detoxification.</li> <li>12. Random drug screening, used to shape behaviors and</li> </ol>

\* See performance standard for service referenced.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p>reinforce treatment gains as appropriate to the MHTP.</p> <p>13. Clinical services to assess and address the youth's withdrawal status and service needs. May including nursing and medical monitoring, use of medications to alleviate symptoms, individual or group therapy specific to withdrawal, and withdrawal support.</p>
<b>Admission Criteria</b>	<p><u>All</u> of the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. The identified youth meets SEBD Eligibility criteria for CAMHD (See Appendix B-7), is registered with a Branch and has an assigned MHCC;</li> <li>2. The youth must be between the ages of twelve (12) to eighteen (18);</li> <li>3. The youth has a documented Axis I substance dependence problem that requires clinically managed detoxification services to enable youth to begin to address his/her substance use problems;</li> <li>4. The CSP identifies this service and measurable objectives for outcomes of this service prior to admission;</li> <li>5. There is a reasonable expectation that the youth will be able to achieve the defined measurable goals and objectives identified in his/her CSP within two (2) weeks to one (1) month;</li> <li>6. The youth is at imminent risk for acute services without this intervention;</li> <li>7. An adequate trial of active treatment in a less restrictive setting has been unsuccessful or given serious consideration and found to be inappropriate; and</li> <li>8. Youth meets one (1) of the following criteria: <ol style="list-style-type: none"> <li>a. Youth is experiencing mild to moderate withdrawal symptoms with no need for psychopharmacological intervention;</li> <li>b. Youth is experiencing high craving states typical of withdrawal, requiring containment and increased intensity of treatment because of lack of sufficient impulse control, coping skills or supports to prevent immediate continued use; or</li> <li>c. Continued use would place the youth at risk of serious damage to his/her physical health because of a biomedical condition or imminently dangerous patter of high-risk use.</li> </ol> </li> </ol>
<b>Initial Authorizations</b>	<p>Authorization may be up to fifteen (15) units by the MHCC.</p> <p>Unit = one (1) day</p>
<b>Re-Authorization</b>	<p>Re-authorization may be up to fifteen (15) units up to one (1) month with approval of the MHS1.</p> <p>Unit = one (1) day</p>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

<b>Continuing Stay Criteria</b>	<p><u>All</u> of the following criteria are met as determined by treatment team review:</p> <ol style="list-style-type: none"> <li>1. All admission criteria continue to be met;</li> <li>2. Services/items are being provided as indicated in the CSP and MHTP and there are regular and timely assessments and documentation of youth/family response to services. Timely and appropriate modifications are made to services and plan as needed;</li> <li>3. The youth still requires clinically managed detoxification services;</li> <li>4. The youth continues to have specific clinically managed detoxification needs that indicate that this is the most appropriate means of addressing those needs; and</li> <li>5. There is a reasonable expectation that the youth can achieve his/her defined measurable treatment goals and objectives as identified in the youth's MHTP within the next two (2) weeks.</li> </ol>
<b>Discharge Criteria</b>	<p><u>One</u> (1) of the following must be met:</p> <ol style="list-style-type: none"> <li>1. The youth no longer eligible for SEBD services. As part of discharge, the MHCC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible;</li> <li>2. Youth has successfully detoxified and is ready to move to a lower level of care to continue treatment;</li> <li>3. The youth/family no longer wants to participate in this service and revokes consent and there is no imminent danger to self or others;</li> <li>4. Youth has demonstrated minimal or no progress toward treatment goals for a one (1) month period and appropriate modifications of MHTP has been made and implemented with no significant success and the CSP determines that the youth is not benefiting from this services at this time; or</li> <li>5. Youth exhibits new symptoms and/or behaviors which cannot be safely and effectively address through this service.</li> </ol>
<b>Service Exclusions</b>	<ol style="list-style-type: none"> <li>1. Not offered at the same time as any out-of-home services;</li> <li>2. Not offered at the same time as any Intensive In-Home, Intensive Outpatient program, Multisystemic Therapy, or Functional Family Therapy except when the youth has a planned discharge from this service within two (2) weeks of referral.</li> </ol>
<b>Clinical Exclusions</b>	<ol style="list-style-type: none"> <li>1. Youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior. Once stable, youth who otherwise meet the eligibility criteria may be referred into the program.</li> <li>2. Youth with acute withdrawal symptoms requiring medical detoxification.</li> <li>3. Youth with a documented substance dependence diagnosis without active withdrawal symptoms.</li> </ol>

### Staffing Requirements:



## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

In addition to the staffing requirement listed in the general standards, these staff requirements must also be followed. If the standards referenced here differ from those in the general standards, these staffing requirements will supersede the general standards.

1. At minimum, two (2) staff shall be on duty per shift per living unit. Staff are always in attendance whenever youth are present.
2. A QMHP experienced in evidence-based substance abuse treatment supervises treatment program and the residential staff. Staff may include: resident counselors, addiction specialists/CSAC, teachers and teaching aides.
3. One or more CSAC(s) is on-site at least forty (40) hours a week.
4. Additional personnel are available and called to duty in emergencies or are scheduled to meet any special needs during busy or more stressful periods such as for one-to-one (1:1) watches, new admissions, staff escort to emergency units, etc.
5. The program's staff Hawaii licensed ABPN child and adolescent psychiatrist or consultant provides psychiatric services at intervals of at least one (1) face-to-face visit a week. The psychiatrist is available for medical emergencies, assessments, and consults. The psychiatrist is on-site for those emergencies that merit face-to-face services within one (1) hour of the call for assistance, and makes direct arrangements with a community hospital in the event a youth is in need of possible hospitalization. This will be duly documented and kept on file at the program. There is established protocol for appropriate qualified medical coverage in the absence of the designated psychiatrist. The psychiatrist has current courtesy or staff privileges at the community hospital within the same county as the program.
6. Depending on the needs of the youth, the services of qualified professionals and specialists in medicine, education, recreation, dietetics, etc., are available among the organization's personnel or through cooperative arrangements.
7. The licensed psychiatrist or psychologist is responsible for the treatment program and for those in care, and provides on-call coverage twenty-four (24) hours per day, seven (7) days a week.
8. A licensed registered nurse is on staff or contracted to establish the system of operations for administering or supervising residents' medications, and medical needs or requirements, monitoring the residents' responses to medications, tracking and attending to dental and medical needs, and training direct care staff to medications and proper protocols.

### Clinical Operations

In addition to the clinical operation requirements listed in the general standards, these requirements must also be followed. If the standards referenced here differ from those in the general standards, these clinical operation requirements will supersede the general standards.

1. Services are available twenty-four (24) hours a day, seven (7) days a week in a secured setting.
2. The program is cognizant of community and client safety and risk issues and has policies and procedures and the mechanisms to effectively manage these issues.
3. The program will not exceed eight (8) youth.
4. Program must have documentation that staff providing services is trained and experienced in treatment of youth with substance abuse and dependency issues.
5. Program has an intake process that includes integration of information available on youth/family in the treatment planning to ensure appropriate and effective treatment. Program also has an established protocol for orienting youth to the program.
6. Provider is to follow all applicable professional practice standards and ethical guidelines.
7. The facility is locked at all times. Twenty-four (24) hour supervision is provided to the youth. Behavioral/treatment plans are closely adhered to with consistency among the staff throughout the programming.
8. The program must adhere to all applicable facility licensing requirements/regulations.
9. Staffing schedules shall reflect overlap in shift hours to accommodate the exchange of information for the continuity of the youths' treatment, adequate numbers of staff reflective of the tone of the

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

unit, appropriate staff gender mix, and the consistent presence and availability of a professional staff for role modeling.

10. The program actively engages youth in planned, structured, therapeutic activities throughout the day, seven (7) days a week. There is a predictable and orderly routine that allows youth to develop and enhance interpersonal skills and behaviors.
11. Families are actively involved and participate in team meetings, program events, therapy sessions, and other activities. They are engaged in opportunities to gain knowledge and practice of what works in the program that can be transferred to the home and community environment.
12. In conjunction with the anticipated short duration of stay, youths' educational needs is not considered a primary focus. However, the program works with the DOE home school to get assignments and ensure transition planning shall consider youth's educational needs such that loss of academic credit is minimized.
13. Program provides structured opportunities for youth receiving instruction from their home school to get support in completing their school work.
14. The program has the ability to arrange for appropriate medical procedures, including indicated laboratory and toxicology testing.
15. At least one (1) staff member per shift is required to have a current CPR and First Aid certification.
16. The program has the ability to arrange for appropriate medical and psychiatric treatment through consultation, referral to off-site concurrent treatment services, or transfer to another level of care.
17. Protocols used to determine the nature of the medical monitoring and other interventions required (including nursing and psychiatric care and/or transfer to a medically monitored facility or an acute care hospital) are developed and supported by a psychiatrist knowledgeable in addictions.
18. Please see Section I General Standards for additional clinical operation requirements:
  - D. Co-Occurring Disorders;
  - F. Referral Process for Services:
    - Referral Acceptance;
  - G. CAMHD Continuity of Care;
  - H. Staffing;
  - I. Supervision;
  - J. Evaluation of Staff Performance;
  - K. Credentialing Requirements;
  - L. Medication Monitoring / Tracking;
  - N. Service Quality;
  - O. Minimum Reporting Requirements;
  - P. Risk Management:
    - Criminal, Child Abuse, and Background Screening;
    - Safety;
    - Restraints and Seclusion;
    - Sentinel Events and Incidents;
    - Police.

### Documentation

In addition to the documentation requirements listed in the general standards, these requirements must also be followed. If the standards referenced here differ from those in the general standards, these documentation requirements will supersede the general standards.

1. Please see Section I General Standards for additional documentation requirements:
  - E. Service Planning:
    - Mental Health Treatment Plan including transition, crisis and discharge planning;
    - Discharge Summary;
  - M. Maintenance of Service Records:

- Progress Notes;
- O. Minimum Reporting Requirements:
  - Monthly Treatment and Progress Summary;
  - CAMHD Attendance and encounter records.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### T. PARTIAL HOSPITALIZATION

<b>Definition</b>	Day programming in the outpatient area or clinic of a licensed JCAHO certified hospital or other licensed facility that is Medicare certified for coverage of partial hospitalization that allows for a more intensive milieu treatment with a focus on medical/psychiatric resources. This service available to stabilize a youth whose psychiatric condition needs a high level of monitoring to stabilize symptoms or as a transition step for youth who have been in more restrictive settings. The primary goal of the partial hospitalization programs is to keep youth connected with his/her family/community while providing short-term intensive treatment.
<b>Services Offered</b>	<ol style="list-style-type: none"> <li>1. The program offers time-limited, ambulatory, intensive coordinated clinical services by a multi-disciplinary team. The services include an intensive structured treatment milieu, an education program, therapy and activities designed to improve the functioning of the youth served.</li> <li>2. The programming is family-centered and includes evidence based interventions which must include weekly individual therapy, daily educational programming, culturally relevant recreational activities, and other planned activities appropriate to young adult or youth's needs including Group Therapy* and Family Therapy* at least two (2) times a month.</li> <li>3. The program provides therapeutic activities designed to improve behavior and functioning. A normalized routine and an orderly schedule to develop positive interpersonal skills and behaviors.</li> <li>4. A child and adolescent psychiatrist is the lead clinician and provides observation, assessments and/or treatment at least weekly. These are individualized to meet the needs of the young adult or youth. Routine assessments are performed by the psychiatrist to effectively coordinate all treatment, manage medication trials and/or adjustments, minimize serious medication side effects, and provide medical management of all psychiatric and medical problems. A psychiatrist is available during program hours to direct any psychiatric emergencies.</li> </ol>
<b>Admission Criteria</b>	<p><u>All</u> of the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. The identified young adult or youth meets SEBD Eligibility criteria for CAMHD (See Appendix B-7), is registered with a Branch and has an assigned MHCC;</li> <li>2. It is determined that appropriate functioning depends on receiving this specific treatment and not providing this treatment would result in a significant deterioration in functioning;</li> <li>3. There is reasonable expectation that treatment will remediate symptoms and/or improve behaviors or there is reasonable evidence that the youth will decompensate or experience</li> </ol>

\* See performance standard for service referenced.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p>relapse if services are not initiated;</p> <ol style="list-style-type: none"> <li>4. The youth is experiencing moderate behavioral and/or emotional symptoms, due to a psychiatric disorder, manifested by a moderate risk for self-injury, injury to others, delay in appropriate developmental progress, deterioration in ability to fulfill age-appropriate responsibilities, presence of stress-related physical symptoms, decompensation, or relapse;</li> <li>5. An adequate trial (as determined by treatment team) of active treatment at a less restrictive level has been unsuccessful or the young adult or youth is clearly inappropriate for a trial of less restrictive services; and</li> <li>6. The youth is at significant risk for needing more restrictive levels of care and/or return to more restrictive levels of care due to the young adult or youth's moderate to severe behavior in the home or community.</li> </ol>
<b>Initial Authorizations</b>	<p>Initial authorization may be up to five (5) units with approval of the Clinical Director.</p> <p>Unit = one (1) day</p>
<b>Reauthorization</b>	<p>Reauthorization may be up to five (5) units with approval of the Clinical Director.</p> <p>Unit = one (1) day</p>
<b>Continuing Stay Criteria</b>	<p><u>All</u> of the following criteria must be met as determined by clinical review every week:</p> <ol style="list-style-type: none"> <li>1. All admission criteria continue to be met;</li> <li>2. Services are being provided per MHTP/CSP as documented in progress summaries and plan reviews;</li> <li>3. There are regular and timely assessments and documentation of the youth/family response to interventions. Timely and appropriate modifications to the treatment plan are made that are consistent with the youth/family status;</li> <li>4. A discharge plan has been formulated and regularly reviewed, revised, and appropriately implemented in a timely manner, identifying specific discharge criteria to be met, and includes specific target dates for reaching goals;</li> <li>5. At least <u>one</u> (1) of the following criteria must be met: <ol style="list-style-type: none"> <li>a. Symptoms or behavior persist at a level of severity that was documented upon admission or the most recent procurement for this episode of care, and the projected time frame for attainment of the treatment goals has not been reached. The treatment plan was adjusted to better meet the young adult or youth/family needs, but if not effective, alternative services will be needed;</li> <li>b. Minimal progress toward treatment goals have been demonstrated, and the plan has been modified to more effectively address needs, and there is reason to believe</li> </ol> </li> </ol>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p>that goals can be met within next authorization period; or</p> <p>c. New symptoms have developed and plans have been modified to address these additional behaviors, the behaviors can be safely and effectively addressed, and a less intensive service would not adequately meet the young adult or youth/family needs; and</p> <p>6. There is reasonable expectation that continued treatment will remediate the symptoms and/or improve behaviors or there is reasonable evidence that the youth will decompensate or experience relapse if services are discontinued.</p>
<b>Discharge Criteria</b>	<p>Youth is no longer in need of or eligible for this service due to at <u>one</u> (1) of the following:</p> <ol style="list-style-type: none"><li>1. Targeted symptoms have abated to a level of severity which no longer requires this level of care as documented by attainment of goals in the treatment plan;</li><li>2. Youth has demonstrated minimal or no progress toward treatment goals for a four (4) week period and appropriate modification of plans has been made and implemented with no significant success, suggesting the youth is not benefiting from partial hospitalization services at this time;</li><li>3. Youth exhibits new symptoms which cannot be safely and effectively addressed through partial hospitalization;</li><li>4. Youth/family no longer want services and revoke consent with no imminent danger to self or others; or</li><li>5. The youth is no longer eligible for SEBD services. As part of discharge, the MHCC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible.</li></ol>
<b>Service Exclusions</b>	<ol style="list-style-type: none"><li>1. Not offered at the same time as any out-of-home services;</li><li>2. Not offered at the same time as any Intensive In-Home, Multisystemic Therapy, Functional Family Therapy or Intensive Outpatient program, except when the youth has a planned discharge from partial hospital within two (2) weeks of referral.</li></ol>
<b>Clinical Exclusions</b>	<p>Youth who require intensive one-to-one (1:1) supervision for protection of self and others are precluded from admission.</p>

### Staffing Requirements:

In addition to the staffing requirement listed in the general standards, these staff requirements must also be followed. If the standards referenced here differ from those in the general standards, these staffing requirements will supersede the general standards.

1. A multi-disciplinary team of clinical, educational and direct care personnel provides the medical, psychiatric, educational, culturally relevant recreational and social services required to provide an intensive therapeutic program.
2. The program director is a licensed mental health professional with clinical/administrative experience in child and adolescent psychiatry.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

3. The medical director is a board certified child and adolescent psychiatrist who has overall medical responsibility for the program.
4. The professional staff is comprised of at least the following professionals:
  - a. Board certified/eligible child and adolescent psychiatrist(s);
  - b. Registered nurse(s) (recommend bachelor's level, certified psychiatric nurses);
  - c. Licensed psychologist(s) (consultative);
  - d. Credentialed mental health professional(s);
  - e. Special Education Teacher(s); and
  - f. Activities therapist/ Recreation therapist/Occupational therapist, based on the needs of the population.
5. Adequate care and supervision are provided at all times in accordance with the developmental and clinical needs of the youth served and includes:
  - a. One (1) staff per every four (4) young adult or youth providing continuous supervision;
  - b. Higher staff/youth ratios during periods of greater activity such as shift changes; and
  - c. Availability of additional personnel for emergencies or to meet the special needs of youth served at busier or more stressful periods.
6. The program's personnel include those with:
  - a. Educational and experiential backgrounds which enable them to participate in the overall treatment program and to meet the emotional and developmental needs of the persons served; and,
  - b. The personal characteristics and temperament suitable for working with youth with special needs.

### Clinical Operations

In addition to the clinical operation requirements listed in the general standards, these requirements must also be followed. If the standards referenced here differ from those in the general standards, these clinical operation requirements will supersede the general standards.

1. Service is available six (6) hours a day, five (5) working days.
2. Service delivery must be preceded by a thorough assessment of the young adult or youth and their family so that an appropriate and effective treatment plan can be developed. A complete Intake, Screening, and Assessment are provided to each young adult or youth prior to or upon admission.
3. The provider is to follow all applicable professional practice standards and ethical guidelines.
4. The Contractor has established procedures/protocols in place for managing crises and effectively and efficiently through the direct interventions of its professional clinical and medical staff. Included in these procedures is the handling emergency and crisis situations that describe methods for triaging youth who require more intensive interventions. Request for police/crisis hotline assistance are limited to situations of imminent risk of harm to self or others.
5. The program provides continuous observation and safe control of behavior (i.e., adequate/appropriate suicidal/homicidal precautions) to protect the patient and others from harm, neglect, and/or serious abuse. These control measures should be used sparingly and under the direction of a child and adolescent psychiatrist. The use of restrictive forms of behavior control must follow JCAHO guidelines.
6. If the program provides services to a mixed population of those in a hospital setting and those who live at home with their families, it assures that both the resident and partial hospitalization youth served receive a comprehensive program that meets their needs.
7. Professional staff works closely together to provide integrated care. They meet weekly to review each case.
8. The program has clear procedures, which specify its approach to behavior management. These require safe, standardized methods for behavior control and management, which indicate the conditions under which restrictive practices such as restraint, and isolation may be used. They

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

also include the procedures for obtaining informed consent from family or guardians regarding such practices.

9. The organization provides training for its personnel in family-based interventions and other alternative ways of dealing with aggressive or out of control behavior, methods of de-escalating volatile situations and of using non-physical techniques in such situations.
10. Up to seven (7) bed hold days may be used to hold the bed of a young adult/youth who is absent from the program as defined in the general standards.
11. Please see Section I General Standards for additional clinical operation requirements:
  - D. Co-Occurring Disorders;
  - F. Referral Process for Services:
    - Referral Acceptance;
  - G. CAMHD Continuity of Care;
  - H. Staffing;
  - I. Supervision;
  - J. Evaluation of Staff Performance;
  - K. Credentialing Requirements;
  - L. Medication Monitoring / Tracking;
  - N. Service Quality;
  - O. Minimum Reporting Requirements;
  - P. Risk Management:
    - Criminal, Child Abuse, and Background Screening;
    - Safety;
    - Restraints and Seclusion;
    - Sentinel Events and Incidents;
    - Police.

### Documentation

In addition to the documentation requirements listed in the general standards, these requirements must also be followed. If the standards referenced here differ from those in the general standards, these documentation requirements will supersede the general standards.

1. Comprehensive multi-disciplinary assessments are performed within forty-eight (48) hours and include comprehensive DSM-IV assessments on Axes I-V, assessments of patient, family, community strengths/resources, and specific multi-modal treatment recommendations that target the specific factors that precipitated the admission and those that require stabilization in order to return to a less restrictive setting. The assessment also includes comprehensive evaluations of the patient's developmental milestones and course; family dynamics, strengths and capacity to be actively involved in family centered interventions; current and past school, work, or other social role; ability to interact socially (including peer relationships); substance use/abuse; and a summary of all prior psychiatric hospitalizations, medication trials, and other mental health/psychosocial interventions including an assessment of the young adult or youth's degree of success and/or failure.
2. At least every three (3) program days progress notes by the responsible psychiatrist, mental health professional, registered nurse and educational specialist are placed in the youth's chart.



3. Please see Section I General Standards for additional documentation requirements:
  - E. Service Planning:
    - Mental Health Treatment Plan including transition, crisis and discharge planning;
    - Discharge Summary;
  - M. Maintenance of Service Records:
    - Progress Notes;
  - O. Minimum Reporting Requirements:
    - Monthly Treatment and Progress Summary.

**U. COMMUNITY HOSPITAL CRISIS STABILIZATION**

<b>Definition</b>	This service offers short-term, crisis intervention to young adults or youth experiencing mental health crises. This is a closely supervised, structured alternative to, or diversion from, Acute Psychiatric Hospitalization. Crisis stabilization service is designed for young adults or youth who are experiencing a period of acute stress that significantly impairs their capacity to cope with life circumstances. The service is provided in an accredited community hospital, with crisis family therapy and child psychiatric services via telemedicine arrangements if not available in the hospital.
<b>Services Offered</b>	<ol style="list-style-type: none"> <li>1. Services are available twenty-four (24) hours/seven (7) days a week;</li> <li>2. Services are provided in a twenty-four (24) hour community hospital setting;</li> <li>3. Twenty-four (24) hour emergency services and physician;</li> <li>4. Crisis intervention counseling and supportive individual therapy;</li> <li>5. Intensive family crisis intervention services with a focus on a successful return of the youth to the home;</li> <li>6. Medication assessment and medical management services provided either on-site through community hospital physicians and/or child psychiatry services via telemedicine arrangements;</li> <li>7. Counseling services directed at improving the young adult or youth's ability to cope with daily stressors; manage emotions and behaviors; improve family communication and strengthen interpersonal relationships;</li> <li>8. Services are provided to assist young adult or youth and their families in identifying and securing necessary community supports to assist the young adult or youth after discharge; and</li> <li>9. If acute psychiatric hospitalization is needed after seventy-two (72) hours, transportation to a CAMHD contracted hospital for acute hospitalization services is arranged by the community hospital and the family/legal guardian. Transportation, whenever possible occurs once the young adult or youth is stable and able to travel without urgent response transportation.</li> </ol>
<b>Admission Criteria</b>	<p><u>All</u> of the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. The identified young adult or youth meets SEBD Eligibility criteria for CAMHD (See Appendix B-7), is registered with a Branch and has an assigned MHCC;</li> <li>2. One of the following conditions: <ol style="list-style-type: none"> <li>a. The young adult or youth may be a danger to self, expressing suicidal ideation or is engaging in self-destructive or self-mutilating behaviors;</li> </ol> </li> </ol>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<ul style="list-style-type: none"> <li>b. The young adult or youth may be displaying acute psychotic symptoms such as delusions, hallucinations, or thought disorganization that are unmanageable;</li> <li>c. The young adult or youth evidences lack of judgment and/or impulse control and/or cognitive/perceptual abilities that present a clear and imminent danger to others; and</li> </ul> <p>3. Without this crisis intervention service, the young adult or youth would be at high risk of an urgent transport to acute hospitalization.</p>
<b>Initial Authorizations</b>	<p>Authorization is up to three (3) units and only by prior authorization of the Clinical Director, except in emergency situations that occur during non-business hours.</p> <p>If admission occurs during non-business hours, approval must be received by the appropriate Clinical Director by the next business day.</p> <p>Unit = one (1) day</p>
<b>Re-Authorization</b>	<p>If acute psychiatric hospitalization is needed after seventy-two (72) hours, transportation to a CAMHD contracted hospital for acute hospitalization services arranged by the community hospital and the family/legal guardian. Transportation, whenever possible occurs once the young adult or youth is stable and able to travel without urgent response transportation.</p>
<b>Continuing Stay Criteria</b>	<p>Not applicable.</p>
<b>Discharge Criteria</b>	<p>At least <u>one</u> (1) of the following criteria must be met:</p> <ul style="list-style-type: none"> <li>1. The young adult or youth's target symptoms and/or behaviors have abated;</li> <li>2. The young adult or youth's psychological, social and/or physiological levels of functioning have returned to a level that allows the young adult or youth's safe return to his/her natural environment or lower level of care with the necessary support services;</li> <li>3. Appropriate natural community resources are planned or engaged to reduce stress factors and to stabilize the living environment; or</li> <li>4. Evaluation of the young adult or youth's health and safety status, the severity of the young adult or youth's symptoms or behaviors is such that the young adult or youth requires transferred to a CAMHD contracted acute psychiatric hospital.</li> </ul>
<b>Service Exclusions</b>	<p>Not offered at the same time as all CAMHD out-of-home services.</p>
<b>Clinical Exclusions</b>	<p>Not applicable.</p>

### Staffing Requirements:

In addition to the staffing requirement listed in the general standards, these staff requirements must also be followed. If the standards referenced here differ from those in the general standards, these staffing requirements will supersede the general standards.

1. Staff supervision is provided on a twenty-four (24) hour/seven (7) days a week basis.
2. The program staff must be under the supervision of a QMHP.
3. If indicated by the program's QMHP, suicidal watches may be ordered, and require a staff ratio of one to one (1:1).
4. A board certified/eligible child psychiatrist must be available to the crisis service twenty-four (24) hours/seven (7) days a week. This coverage may be provided via telemedicine connections.
5. The community hospital must provide physician resources to conduct face-to-face evaluation for admission to the crisis service and as necessary for crisis intervention counseling.
6. The family therapy sessions must be provided by a QMHP or MHP under the supervision of a QMHP.

### Clinical Operations

In addition to the clinical operation requirements listed in the general standards, these requirements must also be followed. If the standards referenced here differ from those in the general standards, these clinical operation requirements will supersede the general standards.

1. Service is available to admit patients twenty-four (24) hours a day seven (7) days a week.
2. Programs must have twenty-four (24)-hour emergency services and physician.
3. In conjunction with the anticipated short duration of stay, young adult or youths' education is not considered to be a primary focus. If clinically appropriate and able to be provided, schoolwork may be completed from home school.
4. At a minimum, all young adult or youth must be placed on fifteen (15) minute observation checks during the young adult or youth's first eight (8) hours following admission. After the first eight (8) hours, the visual check frequency is as ordered by the physician and telemedicine psychiatrist.
5. There is daily communication (during work week) between the crisis service and the young adult or youth's CAMHD Branch Clinical Director regarding the young adult or youth's status and progress. The hospital shall contact the young adult or youth's Branch Clinical Director at the time of admission and maintain regular contact.
6. The physical structure of crisis service shall, to the extent possible, prevent elopement.
7. The crisis stabilization service has medical emergency information, plans, and mechanisms to ensure appropriate and timely medical emergency interventions, should the need arise.
8. Severe crisis occurrences shall result in a face-to-face assessment by the community hospital physician and/or telemedicine contact with the child psychiatrist.
9. Assessment and therapeutic intervention are timely, appropriate, and effective.
10. Staff must have at least twenty (24) hours of orientation training including, but not limited to crisis field assessment and intervention, suicide assessment, clinical protocols, proper documentation, and knowledge of community resources.
11. The program must also have documented training on a quarterly scheduled basis, to expand knowledge base and skills relative to crisis intervention and treatment protocols as guided by the agency's training curriculum, and young adult or youth-specific situations experienced by emergency workers.
12. Contractor must have a QMHP that oversees all program staff is and responsible for all clinical decisions made.

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

13. Please see Section I General Standards for additional clinical operation requirements:

- F. Referral Process for Services
  - Referral Acceptance;
- G. CAMHD Continuity of Care;
- H. Staffing
- I. Supervision
- J. Evaluation of Staff Performance;
- K. Credentialing Requirements;
- L. Medication Monitoring / Tracking;
- N. Service Quality
- O. Minimum Reporting Requirements
- P. Risk Management
  - Criminal, Child Abuse, and Background Screening;
  - Safety
  - Restraints and Seclusion
  - Sentinel Events and Incidents
  - Police

### Documentation

In addition to the documentation requirements listed in the general standards, these requirements must also be followed. If the standards referenced here differ from those in the general standards, these documentation requirements will supersede the general standards.

1. Upon admission, the community hospital completes a brief psychosocial evaluation supporting need for placement in crisis stabilization services. The brief psychosocial evaluation must include the nature and status of the crisis, provisional diagnoses, and goals of the brief stay.
2. The crisis stabilization service shall develop a crisis stabilization plan for each young adult or youth admitted to the hospital. The plan shall be detailed, specific to each young adult or youth's needs, including to whom, when and how information is conveyed, and actions to be implemented.
3. Clinical documentation must be recorded and included all significant information available, including, but not limited to: demographic information; signed parental consents to transport (should that be warranted in coming days), and consent to admit at a CAMHD contracted hospital with acute psychiatric services.
4. Individual staff's shift notes observations and interventions that indicate young adult or youth's status.
5. The QMHP progress notes shall reflect clinical observations, progress and therapeutic interventions with a specific focus on both the young adult or youth as well as the parent(s)/caregiver(s).
6. Physician orders to be maintained identifying medications and observed status changes.
7. The Contractor must submit to the MHCC a written discharge summary on all young adult or youth at time of discharge. The discharge summary shall include the duration of service, young adult or youth's adjustment, significant problems or concerns that arose, significant young adult or youth and family accomplishments, discharge orders and status of the young adult or youth.

8. Please see Section I General Standards for additional documentation requirements:
- E. Service Planning:
    - Mental Health Treatment Plan including transition, crisis and discharge planning;
    - Discharge Summary;
  - M. Maintenance of Service Records:
    - Progress Notes;
  - O. Minimum Reporting Requirements:
    - Monthly Treatment and Progress Summary;

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### V. ACUTE PSYCHIATRIC HOSPITALIZATION

<b>Definition</b>	This service offers short-term, emergency implementation of life-saving medical and psychiatric interventions. This is a closely supervised, highly structured milieu that operates twenty-four (24) hours, seven (7) days a week offering a full range of diagnostic and therapeutic services utilizing a multi-disciplinary team and integrated services planning. Services are provided in a <u>locked</u> unit of a licensed hospital facility.
<b>Services Offered</b>	<ol style="list-style-type: none"> <li>1. A highly structured milieu exists that is dedicated to the stabilization and treatment of psychiatric patients;</li> <li>2. Primary medical consultation and is immediately available twenty-four (24) hours per day, seven days per week as well as access to all diagnostic and medical evaluation services;</li> <li>3. R.N. supervision is required twenty-four (24) hours, seven days per week. The nurse observes, assesses and documents the his/her assessment at least once each shift;</li> <li>4. Observation and assessments are performed by a APBN board certified child and adolescent psychiatrist daily;</li> <li>5. Intensive family crisis intervention services with a focus on a successful return of the youth to the home;</li> <li>6. Individual Therapy and as appropriate to youth's needs and</li> <li>7. Medication evaluation management interventions are available as appropriate to the youth's needs.</li> </ol>
<b>Admission Criteria</b>	<p><u>All</u> of the following criteria must be met:</p> <ol style="list-style-type: none"> <li>1. The identified youth meets SEBD Eligibility criteria for CAMHD (See Appendix B-7), is registered with a Branch and has an assigned MHCC;</li> <li>2. At least <u>one</u> or more of the following self harmful criteria has been assessed and cannot be safely managed in a less restrictive level of care: <ol style="list-style-type: none"> <li>a. Youth has made a serious suicide attempt or serious gesture;</li> <li>b. Youth is threatening suicide with likelihood of acting on the threat, and there is an absence of the appropriate supervision or structure to prevent self-harm behavior and safely account for other risk factors;</li> <li>c. Youth is in an unmanageable manic state; or</li> <li>d. Youth is exhibiting self-injurious behavior (cutting self, burning self) or is threatening the same with likelihood of acting on the threat;</li> </ol> </li> <li>3. Youth whose evaluation and treatment cannot be carried out safely or effectively in other settings due to at least one or more of the following imminent danger to others criteria must be: <ol style="list-style-type: none"> <li>a. Youth exhibits serious aggressive, assaultive, or sadistic behavior that is harmful to others;</li> <li>b. Youth has recent onset of aggravated psychotic symptoms; or</li> </ol> </li> </ol>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	c. Presence of medication needs or a medical situation which is life-threatening (e.g., toxic drug level) or which requires an acute care setting for its treatment.
<b>Initial Authorizations</b>	<p>Authorization may be up to three (3) units only by prior authorization of Clinical Director.</p> <p>Admissions after work hours and weekend emergencies are facilitated by the DOH contracted emergency service providers. The Contractor must contact the appropriate Branch Clinical Director the next business day to receive authorization for service.</p> <p>Unit = one (1) day</p>
<b>Re-Authorization</b>	<p>Reauthorization up to three (3) units if patient meets the continuing stay criteria for a maximum of six (6) units in any episode as authorized by the CAMHD Medical Director.</p> <p>Unit = one (1) day</p>
<b>Continuing Stay Criteria</b>	These criteria shall be applied after the initial admission period of up to three (3) days. The youth/young adult must continue to meet the admission criteria.
<b>Discharge Criteria</b>	<p><u>One</u> (1) of the following must be met:</p> <ol style="list-style-type: none"> <li>1. The symptoms of the youth/young adult are characterized by a degree of intensity that no longer requires continual medical/nursing response, management, and monitoring. The youth/young adult's safety and treatment needs can be addressed in a less intensive setting;</li> <li>2. The services provided in the facility cannot reasonably be expected to improve the youth/young adult's condition. Youth/young adult can be treated a lower level of care;</li> <li>3. The youth/young adult is no longer eligible for SEBD services. As part of discharge, the MHCC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible</li> </ol>
<b>Service Exclusions</b>	Not applicable
<b>Clinical Exclusions</b>	Not applicable

### Staffing Requirements:

In addition to the staffing requirement listed in the general standards, these staff requirements must also be followed. If the standards referenced here differ from those in the general standards, these staffing requirements will supersede the general standards.

1. Professional staff must consist of a multi-disciplinary treatment team that works closely together to provide integrated care, meets regularly to review each case and is comprised of at least the following professionals with the stated ratios:



## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

- a. Board eligible/certified ABPN child and adolescent psychiatrist(s) available twenty-four (24) hours a day 1:16;
  - b. Licensed psychologist 1:16;
  - c. Intensive Family/System Therapist Credentialed LCSW, LMFT, or APRN with specialty training in family 1:12;
  - d. Rehabilitation Services Occupational Therapist (OT), Recreational Therapist (RT), and Certified Substance Abuse Counselor (CSAC). Must include CSAC on staff 1:12;
  - e. Special Education certified teacher;
  - f. Licensed Registered Nurse(s) (recommend bachelors-level, certified psychiatric nurses) 1:4. One (1) R.N. minimum on each shift;
  - g. Minimum of two (2) nursing staff at all times.
2. Staff must be CAMHD credentialed.
  3. The program must be under the direction of a Hawaii licensed ABPN child and adolescent psychiatrist.
  4. Psychiatric cover is required and a psychiatrist must be a full time position on the unit.
  5. Program staff ratios need to be adjusted during periods when acuity is high or there is greater activity.
  6. Staffing ratios must apply to Acute population and cannot be counted at the same time for staffing of hospital base residential treatment or other populations.
  7. All staff must have an understanding of and ability to assess symptoms, medication issues, and behavior in order to be able to identify psychiatric situations requiring additional psychiatric or nursing staff assistance.

### Clinical Operations

In addition to the clinical operation requirements listed in the general standards, these requirements must also be followed. If the standards referenced here differ from those in the general standards, these clinical operation requirements will supersede the general standards.

1. Services must operate within a locked unit of a licensed accredited hospital.
2. Service is available to admit patients twenty-four (24) hours a day seven (7) days a week.
3. Programs must have twenty-four (24)-hour emergency services and physician.
4. A Comprehensive Mental Health Assessment\* is completed within twenty-four (24) hours of admission. This assessment must be in the youth/young adult's file with a copy sent to the CAMHD Branch within seven (7) days of admission.
5. A thorough acute stabilization assessment of the family and/or caregiver and other significant systemic influences (other providers, extended family etc.) is completed within twenty-four (24) hours. Interventions are developed (aligned with discharge and crisis plans) that specifically address stabilization and needs related to re-entry to the home (and/or the least restrictive and most appropriate service) in the MHTP.
6. Intensive family crisis intervention is focused on successfully returning the youth/young adult home or to the least restrictive and most appropriate service.
7. The hospital provides timely and effective communication with the family, CAMHD Branch, and other involved agencies regarding any significant event.
8. There is a daily review of progress and assessment of the need for continued stay. This includes an update of the discharge plan. At least every three (3) days there is phone contact with CAMHD Branch regarding the need for ongoing hospitalization any obstacles for discharge and discharge planning. After the ninth consecutive day, contact with the CAMHD Clinical Director is held daily.
9. The service must operate within an JCAHO accredited hospital.

---

\* See performance standard for service referenced.

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

10. The psychiatrist sees each youth/young adult daily and a progress note is placed in their clinical record. Routine assessments are performed to effectively coordinate all treatment, manage medication trials and/or adjustments, minimize serious side effects, and provide medical management of all psychiatric and medical problems. The daily progress note will include a review of treatment plan, progress, and need for service.
11. If medication is indicated, the psychiatrist obtains informed written consent including a discussion of benefits and risks of medication with the parent/legal guardian and as appropriate, the youth/young adult.
12. Treatment plan reviews that include the family and CAMHD Branch staff are held at least every three (3) days (may include telephone conferencing).
13. Please see Section I General Standards for additional clinical operation requirements:
  - F. Referral Process for Services:
    - Referral Acceptance;
  - G. CAMHD Continuity of Care;
  - H. Staffing;
  - I. Supervision;
  - J. Evaluation of Staff Performance;
  - K. Credentialing Requirements;
  - L. Medication Monitoring / Tracking;
  - N. Service Quality;
  - O. Minimum Reporting Requirements;
  - P. Risk Management:
    - Criminal, Child Abuse, and Background Screening;
    - Safety;
    - Restraints and Seclusion;
    - Sentinel Events and Incidents;
    - Police.

### Documentation

In addition to the documentation requirements listed in the general standards, these requirements must also be followed. If the standards referenced here differ from those in the general standards, these documentation requirements will supersede the general standards.

1. All services delivered by the treatment team are documented and progress notes placed in the file within eight (8) hours after the services are delivered. Progress notes written by residents or interns are co-signed by a supervising professional within forty-eight (48) hours.
2. The registered nurse caring for the patient must write a progress note daily.
3. The psychiatrist is to see each patient daily and write a progress note for the clinical record. Routine assessments are performed to effectively coordinate all treatment, manage medication trials and/or adjustments, minimize serious side effects, and provide medical management of all psychiatric and medical problems. The daily progress note will include a review of treatment plan, progress, need for services and address any barriers to discharge.
4. Please see Section I General Standards for additional documentation requirements:
  - E. Service Planning:
    - Mental Health Treatment Plan including transition, crisis and discharge planning;
    - Discharge Summary;
  - M. Maintenance of Service Records:
    - Progress Notes;
  - O. Minimum Reporting Requirements:
    - Monthly Treatment and Progress Summary;
    - CAMHD Attendance and encounter records.



***SECTION III:***

**INTERAGENCY  
PRACTICE GUIDELINES**

**FOR THE PROVISION OF SCHOOL – BASED  
BEHAVIORAL HEALTH SERVICES & INTENSIVE MENTAL HEALTH TREATMENT  
SERVICES**

## **SECTION III: INTERAGENCY PRACTICE GUIDELINES**

### **I. INTRODUCTION:**

The Child and Adolescent Mental Health Division (CAMHD), a division of the State of Hawaii Department of Health (DOH), and the Student Support Branch (SSB), a division of the State of Hawaii Department of Education (DOE), share the responsibility for providing behavioral and or mental health services to children and families throughout Hawaii. In joining the resources of schools, CAMHD Branches, service provider agencies and community resources, the DOE and DOH hope to maintain a comprehensive system for the provision of supports and services to all children at risk for or experiencing behavioral and or emotional disabilities.

These guidelines provide direction regarding the supervision of staff providing behavior and or mental health services. They are proposed as part of an ongoing effort by DOH-CAMHD and DOE-CSSS to ensure quality behavior and or mental health services and supports for students/youth. These guidelines are drawn from a multidisciplinary evaluation of research, based on a formal and scientific literature review (conducted by the CAMHD Evidence-Based Services Committee) of practice guidelines and controlled studies in psychology, psychiatry, education and related behavior health disciplines.

In general, these guidelines reflect CAMHD and DOE policies that scientific evidence is a significant criterion governing service delivery. In other words, the assessment and intervention services valued most highly are those that are supported by careful research demonstrations of their positive effects (i.e., “use what works”). The guidelines are intended to be used by behavior health practitioners to support youth, students, families, and teachers in the search for those approaches with credible evidence for having helped other children in the past. The approaches described below are not to be applied mechanically in the absence of clinical judgment; however, these approaches are believed to be the most promising starting points for assessment and intervention with children and adolescents. Finally, these guidelines are intended to discourage the use of interventions or behavior plans with known risks and to encourage the use of “alternative” approaches only when the most promising interventions and supports have been tried with integrity and have not been successful, or when extremely compelling circumstances preclude the use of the most promising approaches first.

#### **A. SUPERVISION AND OUTCOME-BASED PLAN EVALUATION**

Provision of interventions and supports should be accompanied by formal supervision. In the research literature, positive outcomes have not been documented in the absence of supervision, suggesting that it represents a critical component to service delivery. Supervision is intended to provide the following to those individuals working with the child: guidance and support, acquisition of new skills, additional perspective, sharing of responsibility, and connection to a larger system of resources. Primary features of supervision are to ensure the integrity of the supports and services the child is receiving and to troubleshoot challenges as they arise. Supervision should occur on a regular basis and should involve the tracking of specific objectives and progress toward overall goals.

Figure 1. Supervision Decision Making Framework

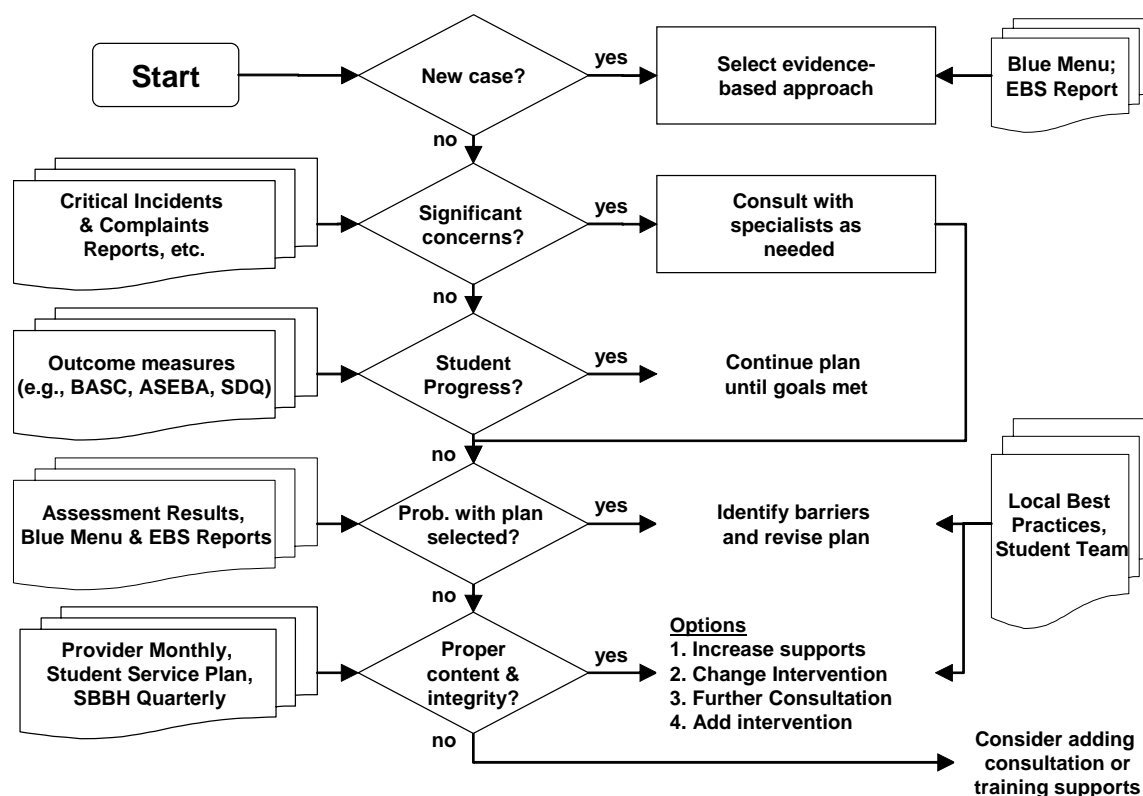


Figure 1 shows that a primary decision faced with a new case is that of intervention selection/plan development. This decision should make use of available evidence-based reports (e.g., EBS Biennial Report; “Blue Menu” Summary of Evidence-Based Psychosocial and Pharmacological Services) in conjunction with these practice guidelines to select appropriate strategies. For newly identified youth, this most likely involves performing an assessment (FBA, EBA, or MHA depending on the complexity of the case), followed by service planning that includes matching the newly acquired information to relevant evidence-based intervention strategies.

As the supports and services are implemented, ongoing supervision and/or care coordination addresses the question of whether urgent concerns have emerged for the case. Here, supervision should prioritize review of student/youth-specific evidence (information about the student/youth in question), e.g., “Critical Incidents, Complaints Reports, etc.” in the context of similar local aggregate evidence (information about programs and services in the Hawaii system) to determine the typical frequency of such incidents in the practice system. For example, if two episodes of aggression are reported for a student/youth and local aggregate evidence indicates an elevated rate of aggression at a particular service setting associated with temporarily increased staff vacancies, the solution may involve managing the temporary staff vacancies rather than fundamentally altering the student/youth’s service plan. Alternatively, critical incidents without a clear explanation may call for the reconsideration of the intervention selection or the application of a specialists’ application of behavioral and clinical judgment.

Supervision next proceeds to the question of whether the student/youth is making progress as measured by the goals outlined in the relevant plans. Here, decision making prioritizes the **student/youth-specific evidence** in the clinical reports (e.g., student's clinical or functional outcome measures, such as the BASC, Achenbach Scales, or CAFAS) to inform this decision. If the student is making progress, continuation of the current plan is recommended. If a student is not improving, the appropriateness of the plan is best reconsidered. Individual outcome information, assessment results, and evidence-based reports (e.g., EBS Biennial Report; "Blue Menu" Summary of Evidence-Based Psychosocial and Pharmacological Services) are prioritized for guiding this decision. If it becomes clear that a plan is comprised of elements with minimal scientific support, then the primary assumption is that one should revise the plan to select a more evidence-based approach.

If the student/youth is not improving despite the proper selection of an appropriate, evidence-based approach, then the next decisions concern the quality and integrity of the intervention provided. This inference involves review of (1) the specific practices that are a part of the evidence-based plan (e.g., EBS Biennial Report Practice Elements Profiles, treatment protocol manuals, proprietary evidence-based intervention adherence measures, or evidence-based expert consultation), (2) the practices that were part of other effective implementations in the local environment, and (3) the practices that were used with the specific case in question (e.g., using a service monitoring strategy such as review of the Student Service Plan, the SBBH Quarterly Progress Report which includes the quarterly BASC-2 Student Observation System, and/or the CAMHD Provider Monthly Progress and Treatment Summary).

If significant discrepancies are observed between practice strategies in the individual case and those summarized from the EBS Biennial Report, then revisions to the specific content of the plan may be warranted. For example, a student receiving intervention for depression who is not improving after several months may require a service plan review. If that review demonstrates the absence of *relaxation* (i.e., training the youth in skills to decrease physiological arousal) in the treatment plan, which is shown to be a component of the majority of evidence-based treatment protocols for depression, then the team may consider adding *relaxation* to the existing set of services.

If at this stage, other problems with intervention quality or integrity are identified (e.g., faulty implementation of *relaxation* procedures), then additional consultation or training is recommended to improve service quality and increase integrity. On the other hand, if no integrity problems are identified, then a difficult situation is encountered, on which it is best to focus a system's expert resources, which are often limited. At this point, evidence requirements may need to be relaxed and the "next best" evidence from all sources be applied to find interventions (e.g., increase supports, change or add interventions) and/or expert consultants who may wish to apply aspects of behavioral or clinical judgment (e.g., "reinforcement can be used to increase desirable behaviors;" "targeting family enmeshment can reduce clinical symptoms in a problem family member") in the hope of identifying a strategy that would lead to therapeutic change.

A record of student/youth progress will be maintained through regular reporting of progress measures on one or more dedicated information management systems (e.g., ISPED, CAMHIS).

### B. INTERVENTIONS AND SUPPORTS

The following section details a list of considerations for interventions and supports relevant to common behavioral and or mental health problem areas for children. Interventions and supports are described at the level of treatment “families” (e.g., Cognitive Behavior Therapy, Structural Family Therapy, Classroom Behavior Management) as well as at a more specific level of detail involving “practice elements” (described below). Each area also includes information regarding additional assessment and other considerations.

#### Practice Elements

As part of an initiative to develop better strategies for measuring and defining practice, the EBS Committee recently reviewed all available evidence-based protocols for their specific component strategies. That is, intervention protocols were coded in terms of the presence or absence of each of 55 “practice elements.” Example practice elements are strategies such as “relaxation,” or “assertiveness training.”

The profiles resulting from the practice element coding represent the relative frequency with which each element was included in a protocol that was efficacious for a particular problem. For example, a value of 80% for “relaxation” on a “depression” profile would indicate that 80% of the coded evidence-based protocols targeting depression included relaxation in their approach. As described above in the section on supervision, these profiles are intended to be referenced the supervisory review of the appropriateness of a service plan, particularly in the absence of observed progress on plan objectives.

## II. ATTENTION PROBLEMS AND HYPERACTIVITY (E.G., ADHD)

### A. ASSESSMENT PROTOCOLS SPECIFIC TO ATTENTION PROBLEMS AND HYPERACTIVITY

In addition to procedures outlined in the general assessment guidelines, and congruent with the FBA framework, the following assessment protocols might be of benefit.

1. **Parent and Teacher Reports** of child’s behavior are the most important, economical, and ecologically valid sources of information regarding ADHD. Such discussion with parents and teachers should focus on frequency, duration, and intensity of behaviors observed, and should attempt to identify problematic settings and events (e.g., homeroom).
2. **Rating Scales** specifically focused on ADHD that can be helpful include the following:
  - a. ADHD Rating Scale (DuPaul, 1991), ages 5 to 17
  - b. Swanson-Nolan-and-Pelham (SNAP) Checklist (Swanson & Pelham, 1988)
  - c. Child Attention Problems Scale (Barkley, 1990)
  - d. Connors Rating Scales—Revised (Teacher and Parent Versions; Connors, 1997) [note: the short forms of these scales are preferable for the specific assessment of ADHD], ages 3 to 17
  - e. School Situations Questionnaire (Barkley, 1997)
  - f. Werry-Weiss-Peters Activity Scale (Routh, Schroeder, O’Tuama, 1974)
3. **Behavioral Observation** of children in home or classroom settings can be very useful for identifying specific aspects of behavior related to ADHD. However, such procedures are less efficient than the above methods, and may provide limited new information beyond parent and teacher interview. Behavioral observation is most useful for cases in which assessment



questions are unusually complex or remain unresolved following more parsimonious assessment strategies.

4. **Continuous Performance Tests (CPTs)** for ADHD have also been shown to be helpful in some instances. It should be noted, however, that the rate of false negatives for such tests is unacceptably high, so that normal CPT scores should not rule out the possibility of diagnosing ADHD. Available CPTs are as follows:
  - g. Connors Continuous Performance Test (Connors, 1995)
  - h. Gordon Diagnostic System (Gordon, 1983)
  - i. Test of Variables of Attention (Greenberg & Waldman, 1992).

### B. OTHER CONSIDERATIONS

The conditions listed below are to be considered during or prior to the initial diagnosis, or upon exacerbation or intervention failure.

1. **Age Appropriate Behaviors in Active Children** are sometimes difficult to distinguish from ADHD. Particular attention should be given to the intensity and pervasiveness of the behaviors to help make this discrimination. Attention, impulsivity, and/or hyperactivity need to occur across more than one setting to warrant a diagnosis of ADHD.
2. **Mental Retardation and Borderline Intellectual Functioning** are associated with attention deficits, particularly when children are placed in classroom settings that are too challenging intellectually. Special care should be taken when diagnosing children with intellectual or cognitive deficits.
3. **Academically Under-Stimulating Environments** are likely to elicit inattention in highly intelligent children. Special care should also be taken when diagnosing children with high intelligence.
4. **Oppositional Defiant Disorder** is associated with avoidance of school tasks. For a diagnosis of ADHD, the avoidance or impulsive behaviors should not be limited to the symptoms of a diagnosable disruptive behavior disorder.
5. **Pervasive Developmental Disorders and Psychotic Disorders** preclude the diagnosis of ADHD. These disorders are commonly associated with gross attention and impulsivity problems and do not allow for the additional diagnosis of ADHD.
6. **Anxiety (Including PTSD)** can affect concentration and attention, and can sometimes be mistaken for ADHD.

### C. COEXISTING/CO-OCCURRING CONDITIONS

The following conditions should be targeted during assessment and if identified should be addressed within the corresponding support plan.

1. **Oppositional Defiant Disorder** has been found to occur by age 7 in 35% to 60% of clinic-referred children with ADHD.
2. **Conduct Disorder** has been found to occur in 30% to 50% of clinic-referred children with ADHD.
3. **Anxiety Disorders** have been found to occur in 25% to 40% of children with ADHD, but this rate falls almost to zero for adolescents. Coexisting anxiety disorders are associated with less impulsivity and are more common with the inattentive subtype of ADHD.

### D. MOST PROMISING PSYCHOSOCIAL INTERVENTIONS

The following interventions are recommended. The frequency, intensity, and duration of each service should be determined based on the comprehensive behavior support plan and should be listed in the student's IEP. The frequency parameters are provided only as guides. All team members should maintain a feedback loop so that optimal results can be achieved.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

**Behavior Therapy** in various forms has been shown to be helpful for children with ADHD.

Behavioral techniques have been tested mainly in children from 6 to 12 years, in clinic and school settings. Both group and individual formats have been supported by research. The two main types of behavioral interventions are as follows:

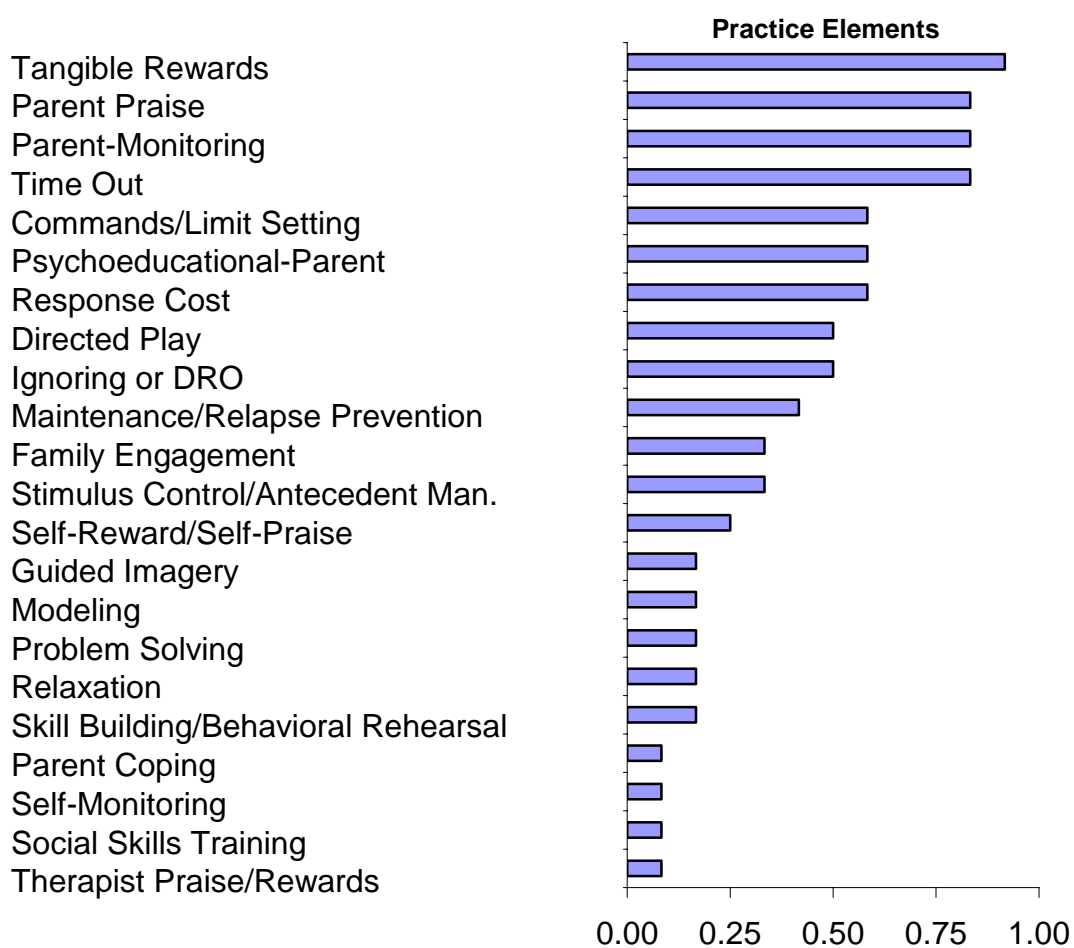
1. **Classroom Behavior Management** involves the establishment of a set of rules, rewards, and consequences within the classroom. These procedures can be implemented daily by a teacher, therapeutic aide, or educational assistant, usually under the guidance of a behavior specialist, consultant, or clinician trained in classroom behavior management strategies.
2. **Parent and Teacher Training** involves working with parents and teachers to establish a set of rules, rewards, and consequences to be applied consistently across the home and school settings. Techniques include Time Out, Communication Training, Active Ignoring, and Reward Contracts (e.g., token or sticker programs). Meetings with parents and teachers usually occur on a weekly basis.

### E. PRACTICE ELEMENTS FOR ADHD

#### Hawaii Evidence-Based Services Practice Profile (as of 7/25/2005)

EBS Level 1 Best Support

Problem(s): 100% Attention & Hyperactivity



### F. ADDITIONAL CONSIDERATIONS

The following are other issues to consider regarding psychosocial interventions:

1. Other Psychosocial Interventions for ADHD have not been supported by research.
2. Interventions with Known Risks have not been identified for ADHD. However, the use of interventions other than those listed above is not recommended as a first choice, given the chronic nature of ADHD. Unsupported interventions for ADHD are much more likely to be associated with poor long-term academic and social adjustment for the child

### G. MOST PROMISING PSYCHOPHARMACOLOGICAL INTERVENTIONS

**Stimulant Medication** has been shown to be the most effective intervention for children with ADHD. In most cases, stimulant medication has about twice the effect of behavior therapy alone in reducing hyperactivity and inattention. There is little evidence that combining behavior therapy with medication has additional effects in reducing impulsivity and inattention. However, there might be some other benefits of adding behavior therapy, such as improvements in social skills, family communication patterns, and lowered dosage of medication. **(See section on Management of Psychiatric Medication below.)**

## III. ANXIETY PROBLEMS AND DISORDERS (INCLUDING PTSD AND OCD)

### A. ASSESSMENT PROTOCOLS SPECIFIC TO ANXIETY PROBLEMS AND DISORDERS

In addition to procedures outlined in the general assessment guidelines, the following assessment protocols can be of benefit.

1. **Child Self-Report** of anxiety is the generally the most valid source of information. These reports may often be inconsistent with parent reports, in that anxiety is often difficult to notice or observe in others. Discussion with children should focus on frequency, duration, and intensity of anxiety, and should attempt to identify problematic settings and events (e.g., bedtime).
2. **Self Report Scales** are more helpful for anxiety disorders than they are for many other childhood disorders. Well studied measures specifically focused on anxiety include the following:
  - j. Multidimensional Anxiety Scale for Children (March, Parker, Sullivan, Stallings, & Conners, 1997), ages 8 to 19
  - k. Revised Children's Manifest Anxiety Scale (Reynolds & Richmond, 1978), ages 6 to 19
  - l. Revised Child Anxiety and Depression Scale (Chorpita, Yim, Moffitt, Umemoto, & Francis, 2000), ages 8 to 18
  - m. Spence Anxiety Scale for Children (Spence, 1997), ages 8 to 12
  - n. State Trait Anxiety Inventory for Children (Spielberger, 1973), ages 9 to 12
3. **Specific Assessment Measures** are sometimes indicated for particular anxiety disorders. Examples include:
  - a. Obsessive-Compulsive disorder: Leyton Obsessional Inventory – Child Version (Berg, Flament, & Rappoport, 1986). A card sort that requires children to identify obsessions and compulsions along with resistance and interference ratings for each.
  - b. Generalized Anxiety Disorder: Penn State Worry Questionnaire for Children (Chorpita, Tracey, Brown, Collica, & Barlow, 1997). A self-report measure of uncontrollable worry in children, ages 7 to 18.
  - c. School refusal or phobia: School Refusal Assessment Scale, Parent and Child Versions (Kearney & Silverman, 1993). Scales designed to illuminate the causes of the child's avoidance of school.

- d. Social Phobia: Social Anxiety Scale—Revised, Child and Adolescent Versions (LaGreca & Stone, 1993). Self report measures of social anxiety, ages 6 to 12.
- e. Specific Fears and Phobias: Fear Survey Schedule for Children—Revised (Ollendick, 1983). Checklist of feared items completed by child, ages 7 to 18.
- 4. **Behavioral Observation** of children in home or classroom settings is sometimes helpful when there is discrepancy among sources of information (e.g., child says he is not afraid to go to school, but parent disagrees). As noted above, observation procedures are more demanding than other methods, and are best used when they are expected to provide important new information about the child's problem. It is important to note that IDEA requires direct observation of referred students.
- 5. **Self Monitoring** is an alternative to behavioral observation that may be of value in similar situations. Children are asked to keep a journal or a diary of anxiety provoking situations, which is then reviewed by the service provider.

### B. OTHER CONSIDERATIONS

The conditions listed below are to be considered during or prior to the initial diagnosis, or upon exacerbation or intervention failure. Most differential diagnosis issues with anxiety disorders involve discriminating among specific syndromes of anxiety.

- 1. **Pervasive Developmental Disorders and Psychotic Disorders** preclude the diagnosis of separation anxiety, specific phobias, and social phobia. These disorders are commonly associated with impaired social functioning or excessive fears.
- 2. **Generalized Anxiety Disorder** is often difficult to distinguish from obsessive-compulsive disorder, social phobia, posttraumatic stress disorder, and depression. The worries associated with generalized anxiety disorder are usually not as specific as those with obsessive-compulsive disorder, and they are not accompanied by rituals. Generalized anxiety disorder needs to involve more domains of worrying than just social events. Worrying that occurs exclusively during the course of posttraumatic stress disorder or depression should not be diagnosed as generalized anxiety disorder.
- 3. **Oppositional Defiant Disorder** can involve avoidance of school, crying, and tantrums similar to those seen with anxiety disorders. However, these oppositional episodes are more pervasive and more controlled or purposeful and more characterized by anger than those associated with anxiety disorders.
- 4. **Attention Deficit Hyperactivity Disorder** may have a similar appearance to anxiety, in that such children have difficulty with concentration and tend to avoid things. However, ADHD usually does not involve the distress, agitation, or inhibition associated with anxiety disorders.
- 5. **Normal Anxiety** is distinguished from anxiety disorders, in that anxiety disorders are in excess of what is considered developmentally appropriate for a given situation. For example, a child who is extremely scared of a school in which there is reasonable chance of violence to him would not be considered to have an anxiety disorder for that reason alone.

### C. COEXISTING/CO-OCCURRING CONDITIONS

The following conditions should be targeted during assessment and if identified should be addressed with the corresponding service plan.

- 1. **Other Anxiety Disorders** occur in 50% to 80% of children with an anxiety disorder. It is not uncommon for children with anxiety disorders to have two or three diagnoses, given the highly differentiated classification of these disorders.
- 2. **Depression** occurs in 5% to 25% of adolescents with anxiety disorders. Depression is less common among children with anxiety disorders.
- 3. **Tic Disorders** occur in 30% of children diagnosed with obsessive-compulsive disorder.

### D. MOST PROMISING PSYCHOSOCIAL INTERVENTIONS

1. **Cognitive Behavior Therapy** has been shown to be helpful for children with anxiety disorders. Standard protocols involve three (3) to sixteen (16) weeks of weekly group or individual therapy, focused on cognitive exercises and assigned practice with the feared situation. These techniques have been tested in children from two (2) to seventeen (17) years, in clinic and school settings. Both group and individual formats have been supported by research. Interventions have included such disorders as social phobia, generalized anxiety disorder, separation anxiety disorder, panic disorder, obsessive-compulsive disorder and posttraumatic stress disorder.
2. **Exposure (Behavior Therapy)** has been shown to be effective in the intervention of anxiety disorders. This intervention is highly variable in frequency and duration, ranging from intensive, single session approaches to daily or weekly sessions over a period of twelve (12) weeks. The intervention involves controlled practice with the feared situation. With obsessive-compulsive disorder, exposure is often paired with “response prevention,” which involves the therapist-assisted resistance of performing compulsions during or after therapeutic practice exercises. Interventions have been found to help children between the ages of three (3) and seventeen (17). Exposure has been used most commonly with specific phobias, separation anxiety disorder, and obsessive-compulsive disorder.
3. **Modeling** involves having children observe others engaging in a feared behavior in order to overcome anxiety. Modeling procedures are commonly incorporated into cognitive behavioral or behavioral intervention approaches, but can be administered alone. Modeling has been tested in children from three (3) to thirteen (13) years, and appears to be most successful with specific phobias (e.g., fear of swimming, animals, etc.).
4. **Parent and Teacher Training** involves working with parents and teachers to establish a set of rules, rewards, and consequences to be applied consistently across the home and school settings. Techniques include Time Out, Communication Training, Active Ignoring, and Reward Contracts (e.g., token or sticker programs).

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

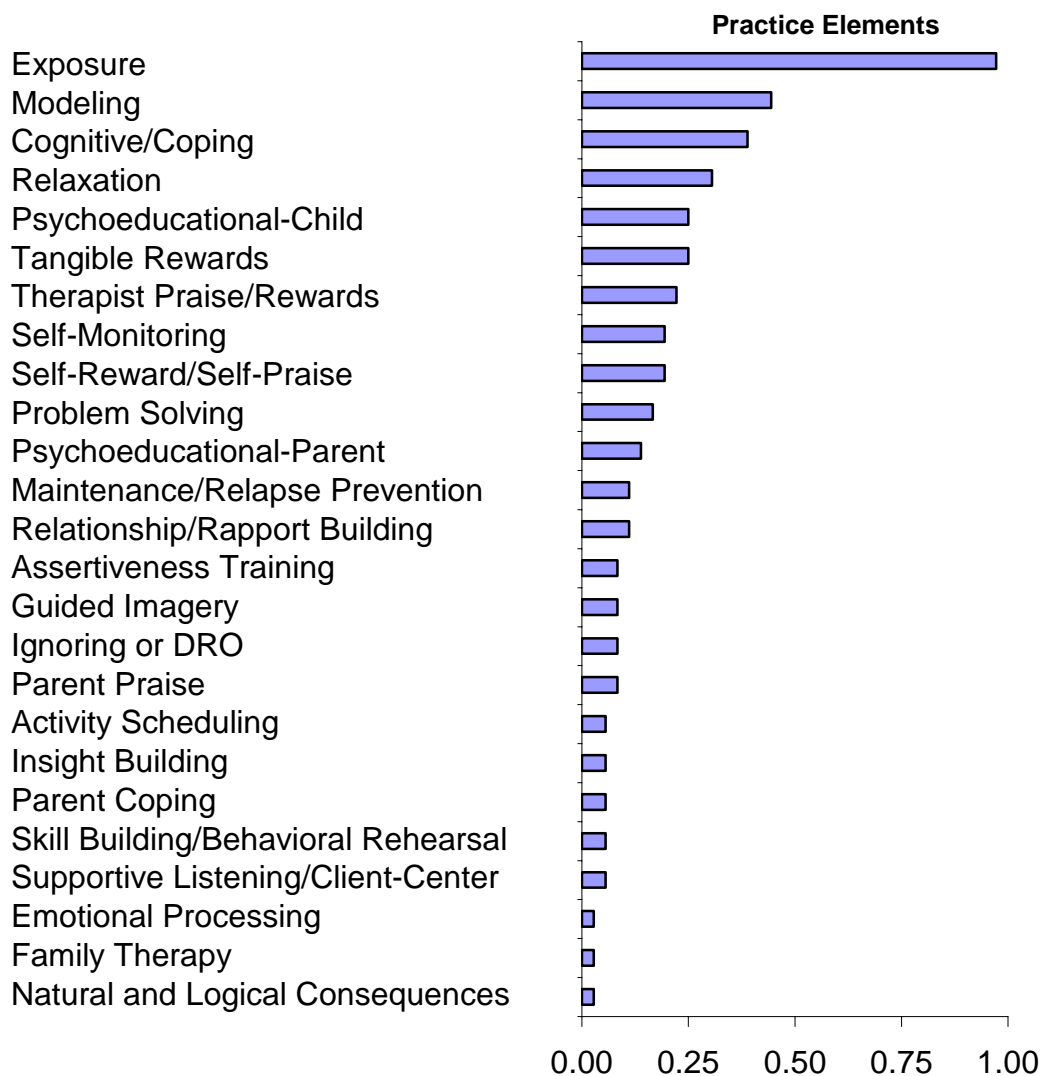
---

### E. PRACTICE ELEMENTS FOR ANXIETY

#### Hawaii Evidence-Based Services Practice Profile (as of 7/25/2005)

EBS Level 2 Good Support or Better

Problem(s): 100% Anxious/Avoidant



### F. ADDITIONAL INTERVENTION CONSIDERATIONS

1. **Parent Involvement** has been shown to increase the effects of cognitive behavior therapy for children with anxiety. Specifically, if parents are anxious themselves or have an anxiety disorder, the success rates for children are found to increase substantially when parents are included in intervention. Parent interventions include teaching parents how to encourage independence in their child, how not to reward anxious behavior, how to administer rewards for the child's successes, and may sometimes include cognitive behavioral intervention of anxiety disorders in one or both parents.
2. **Educational Support** has been shown in two studies to be helpful for children with anxiety disorders refusing to attend school. Educational support involves structured academic tutoring, and it may be a useful alternative when the interventions outlined above have not been successful.
3. **Disruptive Behavior Disorders** (e.g., oppositional defiant disorder, ADHD) sometimes co-occur with anxiety disorders. In such instances, it is usually necessary to treat the disruptive behavior disorder first, given that successful intervention for anxiety require the cooperation of the child in some difficult exercises. These elements of intervention are often difficult to administer if the child is defiant or uncooperative. Following successful intervention of the behavior problems, a child may be considered an improved candidate for the intervention of the anxiety disorder.
4. **Interventions with Known Risks** include home schooling for anxiety disordered (usually school refusing) children. Home schooling is associated with poor long-term outcome, particularly with children who experience panic disorder, separation anxiety, or social anxiety. Once a child is removed from the school, anxiety can become more severe and pervasive, and can contribute to a sustained pattern of avoidance and poor peer relations. These known costs of home schooling an anxiety-disordered youth need to be weighed very carefully against the expected benefits. In general, the use of interventions other than those listed above is not recommended for the intervention of anxiety. Unsupported interventions for anxiety disorders are much more likely to be associated with poor long-term academic and social adjustment for the child.

### G. MOST PROMISING PSYCHOPHARMACOLOGICAL INTERVENTIONS

Few medications have demonstrated support for the intervention of anxiety disorders in double-blind placebo-controlled studies, with the exception of Selective Serotonin Reuptake Inhibitors for obsessive-compulsive disorder. Nevertheless, case reports, uncontrolled trials, and clinical opinion suggest that benzodiazepines and Selective Serotonin Reuptake Inhibitors might be useful for some anxiety disorders. (See section on Management of Psychiatric Medication below for more detail.)

## IV. PERVASIVE DEVELOPMENTAL DISORDERS (INCLUDING AUTISM)

### A. ASSESSMENT PROTOCOLS SPECIFIC TO PERVASIVE DEVELOPMENTAL DISORDERS

Some of the procedures outlined in the assessment guidelines above may not be entirely applicable to children with pervasive developmental disorders, and a child interview is most commonly replaced by structured observation. The following assessment protocols should be considered as useful strategies:

1. **Observation** is one of the most important aspects of assessment. Care should be taken to observe both play situations (to assess for sensory problems, stereotypy or nonfunctional object use) and social situations (to assess for communication difficulties). Although formal observation scoring systems to exist, their psychometric properties are marginal. Recording

- a list of symptoms observed (along with their frequency and intensity) and appropriate strategies employed (e.g. communication, self-regulation, etc.) during the assessment period and to conduct observation in conjunction with the checklist described below is integral to the assessment.
2. **Diagnostic Interviews and Checklists** are helpful in the assessment of pervasive developmental disorders in children. Measures to consider include the following:
    - a. Childhood Autism Rating Scale (CARS; Schopler et al., 1980, 1986): the most widely used diagnostic instrument for autism. It provides 15 scales related to the child's behaviors. Designed to be used in conjunction with observation of the child.
    - b. Autism Behavior Checklist (Krug, Arick, & Almond, 1980): a 57-item measure usually completed by teachers or parents. Some evidence suggests it is more useful as a screening tool than as a diagnostic tool.
    - c. Autism Diagnostic Interview - Revised (Lord et al., 1994): a structured diagnostic interview to be used with the child's principal care provider.
    - d. Checklist for Autism in Toddlers (Baron-Cohen, Allen and Gillberg, 1992): a brief screening instrument designed specifically for early detection of autism in children of about 18 months of age.
    - e. Autism Diagnostic Observational Schedule – Generic (ADOS-G; Lord, et. Al., 1989): a semi-structured assessment of communication, social interaction, and pervasive developmental disorders (PDD). The ADOS-G consists of standard activities that allow the examiner to observe the occurrence or non-occurrence of behaviors that have been identified as important to the diagnosis of autism and other pervasive developmental disorders across developmental levels and chronological ages.
  3. **Intellectual Assessment** is important in the assessment of pervasive developmental disorders. This information should be available in education records. The Stanford –Binet and Wechsler Scales can be used. For children with less adaptive skills or limited verbal skills the Bayley Scales, Leiter International Performance Scales and Ravens Coloured Progressive Matrices may be employed. It should be noted that due to the nature of pervasive developmental disorders the score derived might not be an accurate measure of the child's ability. Multiple methods of intellectual assessment should be employed and scores should be viewed with caution.
  4. **Adaptive Behavior Scales** are important to help identify strengths and weaknesses. Unfortunately, such scales have not been normed for children with pervasive developmental disorders. Nevertheless, scales to consider are the following:
    - a. American Association for Mental Retardation Adaptive Behavior Scale (Lambert, Nihira, & Leland, 1993): identifies strengths and weaknesses in a large number of practical areas related to daily educational functioning, ages 3 to 19.
    - b. Vineland Adaptive Behavior scales (Sparrow et al., 1984): identifies strengths and weaknesses related to communication, daily living, socialization and motor skills in ages 0 to 18.
  5. **Communication** is a vital component of assessment. As there are no assessments that will assess all language components involved in autism multiple measures should be employed. Often it is necessary to employ portions of several standardized assessments to gather meaningful information.
    - a. Language Samples are the most important component of a communication assessment for an individual being assessed for autism. Through observation form, content, use and function of the child's communication should be reviewed.
    - b. Peabody Picture Vocabulary Test. Utilizing the expressive one-word vocabulary and receptive one-word vocabulary sections the ability to discriminate one-word out of context can be determined.



6. **FBA** is a critical component of assessment when children exhibit behavior that impedes their ability to access their education (disruptive, aggressive, self-injurious, self-isolating, internalizing, withdrawal, stereotypy, etc.). Using interview, observation, and record review, the interviewer should attempt to identify the links between settings, antecedents, behaviors and consequences. The goal is to identify factors that predict the occurrence or absence of behavior and establish factors that maintain the behavior or its absence. Some tools to assist in this regard are the following:
  - a. **Motivational Assessment Scale** (Durand & Crimmons, 1988): a 16 item measure for teachers or care providers, designed to identify the maintaining factors for problem behaviors in the areas of attention, escape, self-stimulation and tangible rewards.
  - b. **Functional Analysis Interview Form** (O'Neill, Horner, Albin, Storey and Sprague, 1990): a more time intensive protocol to develop hypothesis about the function of problem behavior in children with autism involving direct observation and scoring by multiple raters (teachers, parents, staff etc.) across multiple domains (home, school, community etc.)

### B. OTHER CONSIDERATIONS

The conditions listed below are to be considered during or prior to the initial diagnosis:

1. **Schizophrenia** may appear slightly similar, but the onset of symptoms occurs much later with schizophrenia (after age of 6 and usually after puberty). Common symptoms of autism (e.g., echolalia, pronoun reversal, auditory sensitivity) are usually absent with schizophrenia. Disorganized speech and behavior and affective flattening are common among both schizophrenia and autism.
2. **Mental Retardation** is diagnosed instead of pervasive developmental disorders when the deficits in cognitive, social, language and motor functioning are all at a fairly uniform level, rather than showing peaks and valleys. Children with pervasive developmental disorders usually are less responsive to social interaction and have superior motor skills to children with mental retardation. Pervasive developmental disorders should only be diagnosed in children with mental retardation when the social and communication problems are consistent with the child's cognitive and developmental level.
3. **Childhood Disintegrative Disorder** involves apparently normal development for the first 2 to 4 years, followed by a significant regression in multiple areas
4. **Rett's Disorder** also begins after a period of apparently normal development, lasting in this case about 9 to 12 months. It occurs only in girls (although a close variant has been observed boys). Gross motor deteriorating and stereotyped hand movements are seen between 6 and 30 months.
5. **Asperger's Syndrome** can closely resemble autism but it does not involve significant language delays in early childhood and individuals have typical or superior cognitive ability.
6. **Developmental Language Disorders** are common in children. However, they do not by themselves involve echolalia, pronoun reversal and non-contextual utterances and the comprehension deficits are less severe than with autism. Also, children with developmental language disorders typically continue to use gestures and facial expressions appropriately and are more capable of conversation than children with autism.

### C. COEXISTING/CO-OCCURRING CONDITIONS

The following conditions should be targeted during assessment and if identified should be addressed with the corresponding service plan.

1. **Mental Retardation** occurs in 70 to 85% of children diagnosed with autism.
2. **Sensory/Perceptual Abnormalities** occur in about 60% of children with autism, particularly in regard to sound.

3. **Self-injury** is relatively common in individuals with autism occurring in about 30% of children and increasing to about 70% when mental retardation is also present.

### D. MOST PROMISING PSYCHOSOCIAL INTERVENTIONS

No comprehensive interventions have been identified in controlled studies that eliminate the condition of autism. The majority of interventions available are focal in nature, i.e., they are designed to address skill for the child with autism.

### E. ADDITIONAL INTERVENTION CONSIDERATIONS

1. **Applied Behavior Analysis (ABA)** while not having been shown to produce normal development does appear to confer benefits to children with autism. These benefits primarily involve the learning of new and adaptive skills, such as self-care and communication.
2. **Functional Behavior Assessment (FBA)** is a component of ABA. Assessments result in a positive behavioral support plan including: team participation, enriched environment, reduced exposure to ecological conditions associated with challenging behavior, increased exposure to environments associated with the use of adaptive behaviors, coaching of functionally equivalent skills, elimination or reduction of gains produced by challenging behavior, expansion of reinforcers, and plans for post intervention and monitoring.
3. **Discrete Trial Training (DTT)** is a component of ABA. DTT is a systematic method of instruction. Instruction is delivered in the following sequence: discriminative stimuli, prompt, behavior, consequence, and a pause between trials. Research on the relationship between the intensity of training and positive outcome has not been consistent. Intensity of services should be individualized.
4. **Functional Communication Training** has been shown to effectively reduce unsafe or challenging behaviors in children with autism. Functional communication training refers to a broad class of strategies that involve a child learning to use verbal and/or augmentative and alternative communication to make requests for immediate needs. Such training substitutes communication for previously employed unsafe or challenging behavior.
5. **Caregiver Education** programs have been shown to increase parents' feelings of confidence and ability in raising a child with autism. Such a program is typically conducted in a group format, with a focus on education about autism and support for parents.
6. **Interventions with Known Risks** have not been specifically identified for autism. However, more so than for many other areas a variety of ineffective interventions are commonly employed. Such interventions may mislead parents or create false hopes regarding the child's development, particular caution is advised when parents consider interventions that has not been supported by research. Parents should be informed that such interventions might not be of help before committing to such services.

### F. MOST PROMISING PSYCHOPHARMACOLOGICAL INTERVENTIONS

At least one antipsychotic medication has some support in double-blind placebo-controlled studies in the reduction of stereotypy, self-injurious behavior and aggression. (See section on Management of Psychiatric Medication below for more detail).

### V. CHILDHOOD SCHIZOPHRENIA

#### A. ASSESSMENT PROTOCOLS SPECIFIC TO SCHIZOPHRENIA

The procedures outlined in the general assessment guidelines may not be sufficient for children with schizophrenia. A child interview should often be supplemented by some structured observation.

#### B. OTHER CONSIDERATIONS

The conditions listed below are to be considered during or prior to the initial diagnosis, or upon exacerbation or intervention failure.

1. **Schizophrenia and Autism** may appear slightly similar, but the onset of symptoms occurs much later with schizophrenia (after age 6 and usually after puberty). Common symptoms of autism (e.g., echolalia, pronoun reversal, auditory sensitivity) are usually absent with schizophrenia. Disorganized speech and behavior and affective flattening are common among both schizophrenia and autism.
2. **Brief Psychotic Disorder** is similar to schizophrenia, with the primary difference being that its duration is less than one month.
3. **Schizophreniform Disorder** is similar to schizophrenia, with the primary difference being that its duration is between one and six months.
4. **Schizoaffective Disorder** is similar to schizophrenia, but involves depressed, manic, or mixed mood episodes concurrent with the symptoms of schizophrenia. This requires at least two weeks of delusions or hallucinations in the absence of mood problems
5. **Mood Disorder with Psychotic Features** can be associated with delusions or hallucinations. It is similar to schizoaffective disorder, except that it does not require a two-week display of delusions or hallucinations in the absence of mood problems.

#### C. COEXISTING/CO-OCCURRING CONDITIONS

The following conditions should be targeted during assessment and if identified should be addressed with the corresponding service plan.

1. **Sensory/Perceptual Abnormalities** occur in more than 60% of children with schizophrenia
2. **Mood Disorders** are present among approximately 37% of children with schizophrenia
3. **Conduct/Oppositional Disorders** are present among 31% of children with schizophrenia

#### D. MOST PROMISING PSYCHOSOCIAL INTERVENTIONS

**No Interventions** have been identified in controlled studies that eliminate the condition of schizophrenia in children.

#### E. ADDITIONAL INTERVENTION CONSIDERATIONS

1. **Family Therapy** and **Assistive Community Treatment** have clear effects on the prevention of psychotic relapse and re-hospitalization *among adults* with schizophrenia. However, these treatments have shown no consistent effects on other outcome measures (e.g., pervasive positive and negative symptoms, overall social functioning, and ability to obtain competitive employment).
2. **Social Skills Training** *among adults* with schizophrenia improves social skills but has no clear effects on relapse prevention, behavior problems, or employment status. Because these treatments have not been tested in controlled studies with children or adolescents, caution must be used in developing a similar treatment strategy.
3. **Interventions with Known Risks** have not been specifically identified for schizophrenia

### F. MOST PROMISING PSYCHOPHARMACOLOGICAL INTERVENTIONS

At least one antipsychotic medication has some support in double-blind placebo-controlled studies in the reduction of stereotypy, self-injurious behavior, and aggression. (See section on Management of Psychiatric Medication below for more detail.)

## VI. CONDUCT AND OPPOSITIONAL PROBLEMS (INCLUDING JUVENILE SEX OFFENDERS)

### A. ASSESSMENT PROTOCOLS SPECIFIC TO CONDUCT AND OPPOSITIONAL PROBLEMS AND DISORDERS

In addition to procedures outlined in the general assessment guidelines, the following assessment protocols can be of benefit.

1. **Parent and Teacher Reports** of child's behavior are very useful sources of information regarding conduct and oppositional problems. Such discussion with parents and teachers should focus on frequency, duration, and intensity of behaviors observed, and should attempt to identify problematic settings and events (e.g., homeroom).
2. **Clinical Interviews** should include some time that allows for observation of the child and parent interaction. Even if only briefly, such observation can yield important subjective information regarding the child's style of interaction with the parent(s), as well as more basic information about the child's cognitive, affective, and behavioral functioning.
3. **Self-Report Scales** are helpful for the assessment of conduct and oppositional disorders in children and adolescents, although these are often not the most reliable source of information and should be considered carefully. Although the Child Behavior Checklist is one of the best studied measures of child behavior problems, other more specific measures include the following:
  - a. Eyberg Child Behavior Inventory (Eyberg, 1992): a parent completed behavioral rating scale designed to assess disruptive behavior in children 2 to 16.
  - b. Sutter-Eyberg Student Behavior Inventory (Eyberg, 1992): a parallel instrument completed by teachers.
  - c. Interview for Antisocial Behavior (Kazdin & Esveldt-Dawson, 1986): a 30 item rating scale completed by parents, which assesses a variety of conduct problem behaviors.
  - d. Children's Hostility Inventory (Kazdin, Rogers, Colbus, & Sielel, 1987): a 38-item scale measuring aggression and hostility.
  - e. Adolescent Sexual Interest Cardsort [*specific to sex offenders only*] (Hunter, Becker, & Kaplan, 1995): a 64-item self report measure of sexual interest, consisting of several vignettes that are rated for their level of arousal.
4. **Peer Functioning and Family Assessment** are very important with oppositional and conduct problems. Because the most successful psychosocial interventions for these problems uniformly involve parents, it is very important that information regarding parenting practices, household chores, discipline, and rules be obtained. Information about what parenting strategies have been tried, and which have worked or failed should be carefully recorded. With respect to peer functioning, information should be obtained about the child's social network, with a particular emphasis on identifying associations with problem peer groups or older children.
5. **Juvenile Court Records**, when available, can provide a reliable history of the child's problem behavior.

### B. OTHER CONSIDERATIONS

The conditions listed below are to be considered during or prior to the initial diagnosis, or upon exacerbation or intervention failure.

1. **Conduct Disorder and Oppositional Defiant Disorder** cannot be diagnosed in the same child at a given time. If criteria of both disorders are met, the diagnosis of conduct disorder is assigned
2. **Attention Deficit Hyperactivity Disorder** can involve impulsivity and difficulty following directions and is sometimes confused with oppositional defiant disorder
3. **Manic Episodes** can involve highly impulsive or irritable behavior. These are distinguished from conduct or oppositional disorders by their episodic course
4. **Normal Development** allows for children who fail to follow directions and who are often angry, particularly in adolescence. The degree of oppositional behavior should be out of proportion to the child's context and much greater than that of his or her peers
5. **Mental Retardation** can involve oppositional behavior. A disruptive behavior disorder is only diagnosed when the problem is markedly greater than that observed among same sex individuals of comparable age and severity of mental retardation

### C. COEXISTING/CO-OCCURRING CONDITIONS

The following conditions should be targeted during assessment and if identified should be addressed with the corresponding service plan.

1. **Attention Deficit Hyperactivity Disorder** is present in 25% to 75% of clinic-referred children and teens with disruptive behavior disorders. The onset of ADHD usually precedes the onset of serious behavior problems, but in many cases can be concurrent.
2. **Substance Use Disorders** occur in 15% to 75% of adolescents diagnosed with conduct disorder. Coexisting/co-occurring substance use diagnoses are a critical predictor of which children will have serious problems in early adulthood
3. **Sexual Abuse History** for juvenile sexual offenders has been reported as approximately 78% for girls and 44% for boys. Abused female offenders are typically abused earlier than abused boys, by a larger number of perpetrators on average. It is important to assess for this additional information and to take appropriate steps if sexual abuse is identified
4. **Physical Abuse History** is relatively more common among children with conduct and oppositional problems. It is important to assess for this additional information and to take appropriate steps if physical abuse is identified.

### D. MOST PROMISING PSYCHOSOCIAL INTERVENTIONS

1. **Parent Training** has been shown to be the most helpful intervention for oppositional defiant disorder, particularly younger children. Parent training involves working with parents to develop specific behavior management strategies. These techniques have been tested in clinic and school settings, in group and individual parent formats. It may not be sufficient for adolescents with conduct disorder (see below).
2. **Multisystemic Therapy** has been shown to be superior to other available interventions for adolescent conduct disorder. It currently appears to be the intervention of choice for severe conduct and delinquency problems. It is also the only intervention approach to date that has demonstrated a positive outcome with juvenile sex offenders in controlled research.
3. **Multidimensional Treatment Foster Care** has been shown to be appropriate for youth ages 9 to 18 whose conduct warrants out-of-home placement. It involves the delivery of parenting strategies similar to those involved in parent training, and incorporates frequent and regular measurement of progress on service plan objectives

### E. ADDITIONAL INTERVENTION CONSIDERATIONS

1. **Anger Coping** has been used with children in a group format to help with mild oppositional behaviors
2. **Assertiveness Training** has also been shown to be helpful for children aged 13 or 14 with mild oppositional problems
3. **Functional Family Therapy** is an intensive, home-based family therapy program that has been shown to assist adolescents ages 13 to 16 with aggression and noncompliance. It is based on many of the same principles as parent management training, described above
4. **Problem-Solving Skills Training** is an approach for youth 7 to 13 that involves intensive training and practice in how to handle challenging situations and to solve interpersonal and social problems without the use of aggression or antisocial behavior.
5. **Rational Emotive Therapy** is similar to cognitive behavior therapy and involves working on correcting problematic thoughts and actions. There is some evidence that this intervention may be helpful for mild oppositional problems in adolescents
6. **Interventions with Known Risks** have been identified for disruptive behavior disorders. The collective evidence suggests that, all other things being equal, group intervention poses a risk of worsening children's aggressive and antisocial behaviors. This observation should be considered carefully when selecting from the interventions listed above.

## F. PRACTICE ELEMENT PROFILES FOR CONDUCT AND OPPOSITIONAL PROBLEMS

### Hawaii Evidence-Based Services Practice Profile (as of 7/25/2005)

EBS Level 2 Good Support or Better

Problem(s): 100% Disruptive or Oppositional, 3%  
Delinquency and Willful Misconduct



### G. MOST PROMISING PSYCHOPHARMACOLOGICAL INTERVENTIONS

Mood stabilizers and antipsychotic medication have some support in double-blind placebo-controlled studies in the reduction of aggressive behavior. (See section on Management of Psychiatric Medication below for more detail.)

## VII. DEPRESSION

### A. ASSESSMENT PROTOCOLS SPECIFIC TO DEPRESSION

In addition to procedures outlined in the general assessment guidelines, the following assessment protocols can be of benefit.

1. **Child Self-Report** of depression is the generally the most valid source of information. These reports may not always agree with parent reports, in that depression is often difficult to notice or observe in others. Discussion with children should focus on frequency, duration, and intensity of depressive episodes, and should attempt to identify problematic settings and events that intensify feelings of depression (e.g., mornings). Also, the interviewer should look for independent past episodes of major depression, and note these accordingly using DSM course specifiers (e.g., single episode versus recurrent).
2. **Self Report Scales** are helpful for the assessment of depression in children and adolescents. Measures to consider include the following:
  - a. Children's Depression Inventory (Kovacs, 1980/1981): the most widely used measure of depression in children and teens, ages 7 to 18.
  - b. Revised Child Anxiety and Depression Scale (Chorpita, Yim, Moffitt, Umemoto, & Francis, 2000): a measure with norms for Hawaii, which includes a depression scale that performs similarly to the Children's Depression Inventory. One advantage is its ability to assess for coexisting/co-occurring anxiety conditions, ages 8 to 18.
  - c. Reynolds Child and Adolescent Depression Scales (Reynolds, 1989): separate depression scales for children and adolescents in grades 3 through 12
3. **Peer Functioning and Family Assessment** are particularly important with depression. The interviewer should try to identify the effects of depression on these relationships and the effects of these relationships on depression. Depression is often associated with diminished perceived support from friends or family. There should also be careful assessment of family history of mood disorders. When one parent has a mood disorder, the risk of the child having a mood disorder is about 25%. When both parents have a mood disorder, the child's risk is about 75%.
4. **Medical Information** is especially important with depression, as many of the symptoms of depression (e.g., poor sleep, no energy) may involve a separate medical condition.

### B. OTHER CONSIDERATIONS

The conditions listed below are to be considered during or prior to the initial diagnosis, or upon exacerbation or intervention failure.

1. Attention Deficit Hyperactivity Disorder often involves poor concentration, irritability, and psychomotor agitation. The clinician should be careful not to over-diagnose depression in children who may have ADHD, particularly when the mood is characterized by irritability rather than by emptiness or sadness.
2. **Adjustment Disorder with Depressed Mood** is characterized by distress and feeling sad, but it requires (1) an identifiable stressor and (2) fewer than the full DSM criteria for depression.



3. **Bereavement** may have an identical appearance to depression, and should be assigned when (1) the depressed mood is in response to the loss of a loved one, (2) the duration is less than 2 months, and (3) there is no marked impairment, morbid worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.
4. **Anxiety Disorders** are sometimes difficult to distinguish from depression. Specific consideration should be given to anxiety disorder criteria when diagnosing depression (see above section on anxiety disorders).
5. **Normal Sadness** is common in children. Depression should not be diagnosed when sadness is not of sufficient intensity and duration or does not cause clinically significant distress or impairment

### C. COEXISTING/CO-OCCURRING CONDITIONS

The following conditions should be targeted during assessment and if identified should be addressed with the corresponding service plan.

1. **Anxiety Disorders** occur in 30% to 75% of children with depression. Anxiety disorders usually have an onset that precedes the depression.
2. **Oppositional and Conduct Disorders** occur in 17% to 79% of children with depression.
3. **Substance Use Disorders** occur in 23% to 25% of children diagnosed with depression. In some cases, substance use may be a response to the depression; in other cases, it may be a precipitant.

### D. MOST PROMISING PSYCHOSOCIAL INTERVENTION

**Cognitive Behavior Therapy** has been shown to be the most helpful intervention for depression in children from 9 to 18 years of age. Standard protocols involve 5 to 16 weeks of weekly or twice per week group or individual therapy, focused on thinking exercises and assigned homework. These techniques have been tested in clinic and school settings.

### E. ADDITIONAL INTERVENTION CONSIDERATIONS

1. **Cognitive Behavior Therapy with Parent Involvement** has also been shown to help children with depression, though in fewer studies than cognitive behavior therapy alone, and only in children from 14 to 18.
2. **Interpersonal Therapy** has also been shown to be helpful for depression. Interpersonal Therapy is a structured intervention that involves weekly individual sessions focusing on improving the impact of interpersonal relationships on mood. Interpersonal Therapy has been tested with children from 12 to 18.
3. **Relaxation** also may help some children with depression. Relaxation involves weekly group meetings for 5 to 8 weeks, designed to teach specific muscle relaxation skills, and it can be administered in a school setting. This approach may not be sufficient for more severe cases of depression.
4. **Interventions with Known Risks** have not been identified for depression. However, interventions other than those listed above are not recommended for depression. Unsupported interventions are much more likely to be associated with poor long-term academic and social adjustment for the child.

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

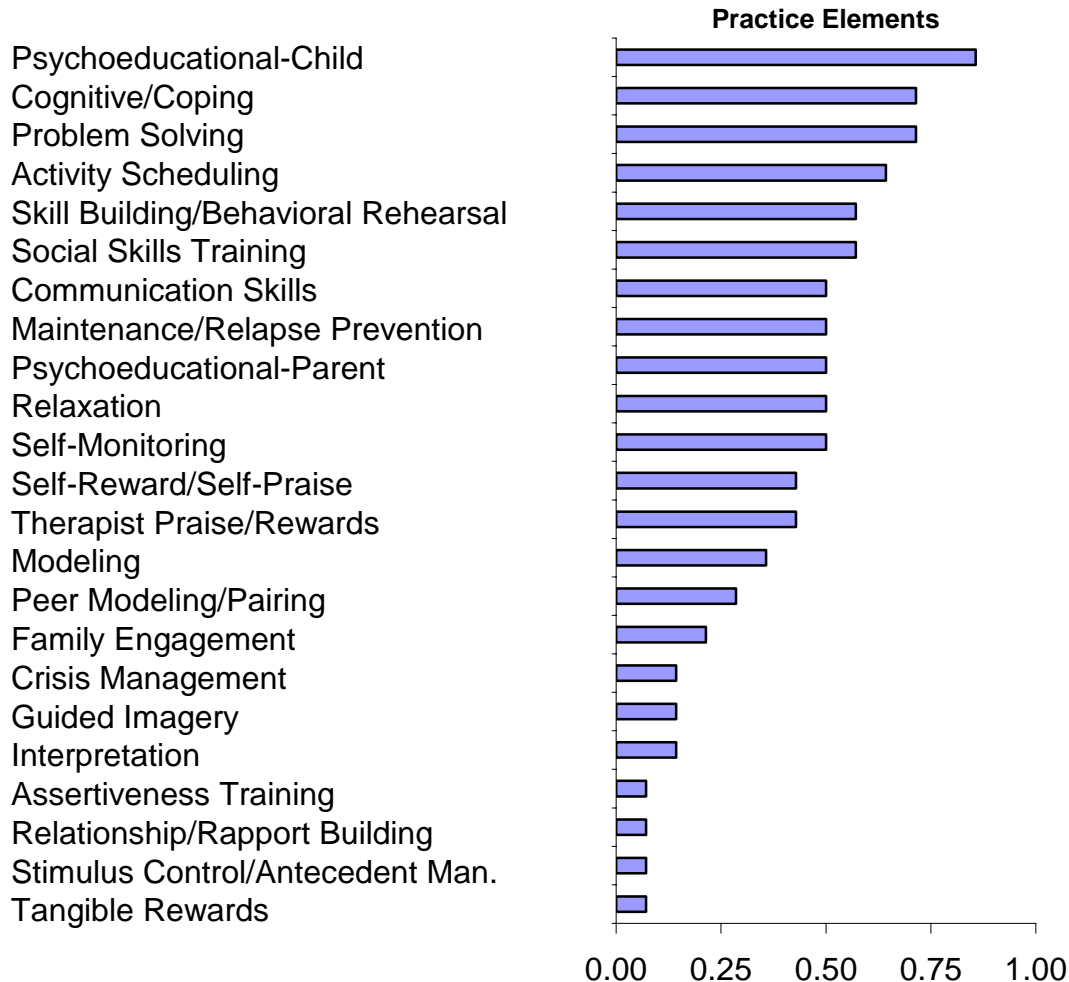
---

### F. PRACTICE ELEMENTS FOR DEPRESSION

#### Hawaii Evidence-Based Services Practice Profile (as of 7/25/2005)

EBS Level 2 Good Support or Better

Problem(s): 100% Depressive or Withdrawn



### G. MOST PROMISING PSYCHOPHARMACOLOGICAL INTERVENTIONS

Selective Serotonin Reuptake Inhibitors have some support in double-blind placebo-controlled studies in the reduction of depression among adolescents. (See section on Management of Psychiatric Medication below for more detail.)

### VIII. EATING DISORDERS

#### A. ASSESSMENT PROTOCOLS SPECIFIC TO EATING DISORDERS

In addition to procedures outlined in the general assessment guidelines, the following assessment protocols may be of benefit.

1. **Medical Information** is essential to obtain with individuals with anorexia nervosa and bulimia nervosa. A routine medical evaluation should include physical examination, standard laboratory tests, multiple-channel chemistry analysis, complete blood count, and urinalysis. A dental evaluation may also be necessary, particularly for individuals who use self-induced vomiting as a compensatory technique. Given the high rate of physical complications and high morbidity rate of eating disorders, particularly Anorexia Nervosa, physical information is vital prior to beginning outpatient intervention. Additionally, medical evaluations should be conducted on a regular basis during the course of intervention, frequency of which would be determined by the physician on the basis of the patient's general health.
2. **Self-Report Scales** are helpful for assessing symptoms of eating disorders, as well as weight and shape concerns. Measures to consider include the following:
  - a. Eating Attitudes Test-26 (EAT-26; Garner, Olmsted, Bohr, & Garfinkle, 1982): A screening instrument that assesses a range of attitudes and behaviors associated with anorexia nervosa. Suitable for use with adolescents.
  - b. Children's Eating Attitudes Test (chEAT; Maloney, McGuire, Daniels, & Specker, 1989): A children's version of the EAT, intended for use with children ages 8-13.
  - c. Eating Disorder Inventory-2 (EDI; Garner, 1991): A measure designed to assess psychological characteristics and symptoms common to anorexia and bulimia nervosa. Suitable for use with adolescents 12 and older—adolescent norms are available.
  - d. Kid's Eating Disorder Survey (KEDS; Childress, Brewerton, Hodges, & Jarrell, 1993): An assessment measure designed for children to assess symptoms of anorexia and bulimia nervosa.
  - e. The Bulimia Test-Revised (BULIT-R; Thelen, Farmer, Wonderlich, & Smith, 1991): The BULIT-R was designed to measure the symptoms of bulimia nervosa. Not suitable for children – 11<sup>th</sup> grade reading level.
3. Food Records/Binge-Purge Diaries: Self-monitoring of behavior, such as food intake and binge-purge episodes can provide valuable information. Food diaries delineate the type and amount of food intake, providing a detailed history of food consumption during a specified time period. Binge-purge diaries may be helpful in ascertaining type and quantity of food consumed, antecedents and consequences of binge behaviors, onset, associated feelings, and time elapsed between binge-purge episodes.

#### B. OTHER CONSIDERATIONS

The conditions listed below are to be considered during or prior to the initial diagnosis, or upon exacerbated or intervention failure.

1. **Anorexia Nervosa vs. Bulimia Nervosa:** In some individuals, those who restrict their dietary intake and also use compensatory techniques (e.g., self-induced vomiting, laxatives, diuretics, diet pills, excessive exercise), it is difficult to distinguish between anorexia nervosa, binge/eating purging type and bulimia nervosa. If the individual meets criteria for anorexia nervosa, then that diagnosis is given along with the specifier of "binge eating/purging type."
2. **Medical Conditions**, such as gastrointestinal disease, brain tumors, occult malignancies, and acquired immunodeficiency syndrome, can all cause significant weight loss. Other, diseases, such as Kleine-Levin disease also causes disturbed eating behavior.

3. **Major Depressive Disorder** can involve a reduction in appetite, with accompanying weight loss.
4. **Anxiety Disorders** and anorexia nervosa have some overlapping features. For example, the fear or embarrassment associated with eating in public as in Social Phobia; the existence of obsessions and compulsions related to food intake as in Obsessive-Compulsive Disorder.

### C. COEXISTING/CO-OCCURRING CONDITIONS

The following conditions should be targeted during assessment and if identified should be addressed with the corresponding service plan.

1. **Major Depressive Disorder** is the most common co-occurring diagnosis for anorexia nervosa, occurring in 21% to 91% of individuals with the disorder. However, it should be noted that depression is a side-effect of starvation, and is often secondary to the onset of anorexia. Rates of depression are also high for bulimia nervosa.
2. **Anxiety Disorders** commonly co-occur with eating disorders. Obsessive-Compulsive Disorder has been most frequently linked with anorexia nervosa, whereas Generalized Anxiety Disorder and Social Phobia have been associated with bulimia nervosa.
3. **Substance Abuse or Dependence** has been estimated to occur in 6.7% to 23% of individuals with anorexia nervosa and 9% to 55% of individuals with bulimia nervosa. For anorexia nervosa, higher rates of substance abuse are found in the binge eating/purging subtype.
4. **Personality Disorders** have been estimated to occur in 27% to 93% of individuals with anorexia nervosa and 33% to 77% of individuals with bulimia nervosa.

### D. MOST PROMISING PSYCHOSOCIAL INTERVENTIONS

The following interventions are recommended. The frequency, intensity, and duration of each service should be determined basis on clinical necessity. The frequency parameters are provided only as guides. All team members should maintain a feedback loop so that optimal results can be achieved.

Unfortunately, there is a lack of controlled research on best interventions for children and adolescents with eating disorders. Listed below are some intervention suggestions that appear to show promise in either the reduction of eating disorder symptoms or in the intervention of adults.

### E. ADDITIONAL INTERVENTION CONSIDERATIONS

1. **Cognitive Behavior Therapy** has been shown to be the most helpful intervention in adults with bulimia nervosa. Although only a few studies have included participants under the age of 17, cognitive-behavioral techniques show promise for adolescents.
2. **Interpersonal Therapy**, which focuses on interpersonal relationships with others, has also been shown to be helpful in the intervention of adults with bulimia nervosa and binge eating disorder.
3. **Family Therapy** (based on the Structural Model of Family Therapy) has been demonstrated to reduce symptoms of anorexia nervosa in adolescents within 1 year. There is some limited evidence that this therapy may be effective for adolescents with bulimia nervosa under the same conditions. Family therapy presumes families whose members are uniformly committed to attending and participating in therapy, and thus may not be applicable to the families of all children and adolescents with eating disorders.

### F. MOST PROMISING PSYCHOPHARMACOLOGICAL INTERVENTIONS

No medications have support in double-blind placebo-controlled studies of child or adolescent eating disorders. (See section on Management of Psychiatric Medication below for more detail.)

### IX. SUBSTANCE USE

#### A. ASSESSMENT PROTOCOLS SPECIFIC TO CONDUCT AND OPPOSITIONAL DISORDERS

In addition to procedures outlined in the general assessment guidelines, the following assessment protocols can be of benefit.

1. **Child Interview** is very important, particularly given that substance use behaviors may not be apparent to the child's parent or teachers. Discussion with the child should focus on frequency, duration, and intensity of use, and should involve discussion of matters of therapist confidentiality regarding substance use issues.
2. **Self Report Scales** can be helpful for the assessment of substance use in adolescents. Some specific measures include the following:
  - a. Adolescent Alcohol Involvement Scale (Mayer & Filstead, 1979): a 14-item self-report measure of severity of alcohol use problems.
  - b. Adolescent Drinking Index (Harrell & Wirtz, 1990): a 24-item self report measure designed to assess loss of control over drinking, and associated psychological, physical, and social consequences.
  - c. Adolescent Alcohol Involvement Scale (Molberg, 1991): a 12-item adaptation of the Adolescent Alcohol Involvement Scale for drug use.
  - d. Personal Experience Screening Questionnaire (Winters, 1991): a 40-item scale measuring presence of substance use problems.
  - e. Rutgers Alcohol Problem Index (White & Labouvie, 1989): a 23-item self-report measure of the personal consequences of alcohol use.
3. **Peer Functioning and Family Assessment** are very important with substance use. The literature suggests that substance use is associated with low parental monitoring of child's activities (e.g., no curfew) and the adolescent's association with a substance using peer group.

#### B. OTHER CONSIDERATIONS

The conditions listed below are to be considered during or prior to the initial diagnosis, or upon exacerbation or intervention failure.

**Substance Abuse and Substance Dependence** are differentiated in that substance dependence often involves tolerance, withdrawal symptoms, increasing doses of the drug, or unsuccessful attempts to control substance use. Substance abuse can only be diagnosed for a given substance when there is no history of dependence for that substance.

#### C. COEXISTING/CO-OCCURRING CONDITIONS

The following conditions should be targeted during assessment and if identified should be addressed with the corresponding service plan.

**Conduct Disorder** is present in 50% to 95% of clinic-referred teens with substance use disorders.

#### D. MOST PROMISING PSYCHOSOCIAL INTERVENTION

**Cognitive Behavior Therapy** has been shown to be the most helpful intervention for substance use, although the evidence is not particularly strong. Studies of CBT for substance use have only been conducted in an inpatient setting, which may have contributed significantly to the positive outcomes observed in those studies.

### E. ADDITIONAL INTERVENTION CONSIDERATIONS

1. **Behavior Therapy** has been shown to help adolescents with substance use problems, and has shown the largest effects of any intervention to date. However, these findings are based on a small number of studies.
2. **Family Therapy** of several types has also been shown to be helpful for adolescent substance use problems, and may be most appropriate for teens whose families are characterized by a high degree of conflict, hostility, or disengagement.
3. **Multisystemic Therapy** has been shown to help reduce substance use when used in the context of treating problems related to willful misconduct.
4. **Interventions with Known Risks** have not been identified for substance use. The evidence from the studies of related areas would suggest that, all other things being equal, group interventions should be considered with caution when such groups might involve contact with children having problems with disruptive behavior.

### F. MOST PROMISING PSYCHOPHARMACOLOGICAL INTERVENTIONS

No medications have support in double-blind placebo-controlled studies of child or adolescent substance use disorders. (See section on Management of Psychiatric Medication below for more detail.)

## X. BIPOLAR DISORDER

### A. ASSESSMENT PROTOCOLS SPECIFIC TO BIPOLAR DISORDER

In addition to procedures outlined in the general assessment guidelines, the following assessment protocols can be of benefit.

1. **Child Self-Report** of bipolar disorder is a very important source of information. Reports on aspects of depressed mood may not always agree with parent reports, in that depression is often difficult to notice or observe in others. Discussion with children should focus on frequency, duration, and intensity of depressive and manic episodes, and should attempt to identify problematic settings and events that intensify feelings of depression and mania (e.g., mornings). Also, the interviewer should look for independent past episodes of major depression or mania, and note these accordingly using DSM course specifiers.
2. **Parent Report and Teacher Report** can also be helpful with respect to identifying manic episodes. Again, discussion should focus on frequency, duration, and intensity of episodes, as well as a review of possible triggers.
3. **Structured Interviews** can be rather helpful with this often difficult diagnosis. The instrument with the best reliability is the Washington University in St Louis Kiddie Schedule for Affective Disorders and Schizophrenia (WASH-U-KSADS), which include detailed mania and rapid cycling sections.
4. **Self Report Scales** can be helpful for the assessment of the depressed phase of bipolar disorder in children and adolescents. There are no well-validated measures of mania for children or adolescents. Specific depression measures are listed below in the depression guidelines.
5. **Family History** is important to assess, as bipolar disorder has been shown to be highly familial. The presence of any mood disorders in a first degree relative increases the child's risk of bipolar disorder approximately 5 times, and the presence of bipolar disorder in a first degree relative increases that risk about 15 times. When one parent has a mood disorder, the risk of the child having a mood disorder (depression or bipolar) is about 25%. When both parents have a mood disorder, the risk is about 75%.

6. **Medical Information** is extremely important with bipolar disorder, as many of the symptoms may involve a separate medical condition.

### B. OTHER CONSIDERATIONS

The conditions listed below are to be considered during or prior to the initial diagnosis, or upon exacerbation or intervention failure.

1. **Attention Deficit Hyperactivity Disorder** often involves poor concentration, irritability, and psychomotor agitation. There is much debate about whether some cases of ADHD are actually bipolar disorder, and the evidence is rather mixed. The most recent evidence has shown that mania in childhood among children with ADHD is not associated with bipolar disorder in adulthood. This suggests that the clinician should be careful not to over-diagnose bipolar disorder in children who may have ADHD along with some symptoms of mania.
2. **Mood Disorder due to General Medical Condition** can cause symptoms similar to bipolar disorder to appear in individuals with such medical conditions as multiple sclerosis and hyperthyroidism. A careful medical screening is often appropriate when bipolar disorder is suspected.
3. **Substance Induced Mood Disorders** may have an identical appearance to bipolar disorder. These, however, are assigned when fluctuations in mood are due to chemical substances, including abused drugs, medication, or exposure to toxins.

### C. COEXISTING/CO-OCCURRING CONDITIONS

The following conditions should be targeted during assessment and if identified should be addressed with the corresponding service plan.

**Attention Deficit Hyperactivity Disorder** has shown some association with bipolar disorder, with clinical attention problems evident in as many as 60% of children with bipolar disorder.

### D. MOST PROMISING PSYCHOSOCIAL INTERVENTION

**No Therapy** has been shown to be helpful for bipolar disorder in children or adolescents, other than medication.

### E. ADDITIONAL INTERVENTION CONSIDERATIONS

1. **Family psychoeducational interventions**, and **interpersonal and social rhythm therapy** have received some modest support in experimental trials *in adults only*. These approaches, when combined with medications, appeared effective in improving long term functioning. A beginning literature also supports the utility of individual cognitive-behavioral and psychoeducational approaches *in adults*, particularly in enhancing medication adherence. Because these interventions have not been tested with children or adolescents, caution must be used if a similar intervention strategy is being considered.
2. **Managing Safety** is an important issue with individuals with bipolar disorder, as about 10 to 15% of these individuals commit suicide at some point in their life. Caution must be taken to ensure that the risk of suicide is being managed appropriately.
3. **Interventions with Known Risks** have not been identified for bipolar disorder.

### F. MOST PROMISING PSYCHOPHARMACOLOGICAL INTERVENTIONS

Mood stabilizers have some support in double-blind placebo-controlled studies of bipolar disorder. In addition, case reports, uncontrolled trials, and clinical opinion suggest that anticonvulsants might also be helpful. (See section on Management of Psychiatric Medication below for more detail.)

### **XI. MANAGEMENT OF PSYCHIATRIC MEDICATIONS**

The research in pediatric psychopharmacology describes the safety and efficacy of medications for a variety of child and adolescent neurological and mental disorders. Prior to a medication approval by the Food and Drug Administration (FDA), extensive tissue culture and animal studies are conducted to establish probable safety, followed by human studies with adult patients who consent to inclusion in studies with placebo controls and randomization to active and placebo intervention groups. After the human safety and efficacy are established, the medication may be dispensed with literature that lists the specific indications and disorders for which the medication has demonstrated efficacy. Caveats in this dispensing literature specify for which ages the medication is not recommended due to lack of studies; this information is updated at least annually in standard pharmaceutical manuals. This approval process requires research that includes randomized, double-blind, placebo-controlled (DBPC) trials which are replicated in several studies and which document in detail the side effects and risks of the medication. Almost all of this preliminary research is conducted on adults with the mental disorders for which the medications are being developed. Research has been conducted less frequently for specific age groups below 12.

Improved antipsychotic medications, anticonvulsant medications with mood stabilizing effects and a new generation of antidepressant medications continue to be introduced in the US at an ever-increasing rate. However, studies in adolescent and pediatric populations have only rarely been conducted to verify both safety and efficacy in younger patients. Research is limited by a number of factors; a serious limitation is the reluctance of parents to expose a seriously disordered child to a randomized intervention, which may be either a placebo or the active medication, when that medication has already been approved for the same disorder in adults. Clinicians raise ethical concerns about conducting long-term safety studies with a control group of children and adolescents receiving a placebo when an active medication has been demonstrated to be effective in other age groups. Pharmaceutical companies generally are satisfied to achieve approval for adults as this approval allows physicians to prescribe for disorders and populations other than those that the original research supports. This practice is called “off label” use. The pharmaceutical industry is not inclined or obligated by FDA requirements to conduct further research. Added costs, consent factors and parental resistance in younger populations related to having a child used in a research study under the necessary conditions result in disincentives to research with younger subjects.

Few studies are long-term, although long-term safety is an important issue with medications for disorders that present in younger patients and persist into adulthood. In the US, the FDA approval process is more detailed and complex, allowing many years of use to accumulate in other countries prior to approval for use in the US. The FDA has an adverse reaction reporting mechanism that continues to collect reports of adverse reactions and other side effects after a medication is approved. As FDA data accumulates, the pharmaceutical dispensing literature and the scientific literature are updated. This includes changes in the recommendations for monitoring medications. Rare adverse effects and effects which take long exposure to emerge often appear only after many years. In recent years, this process has resulted in profound changes in prescribing practices for medications that continue to be approved for use. In the mid-1980s, a medication for depression had serious, potentially lethal, hematological side effects emerge shortly after release; it was very quickly withdrawn from the US market. In the past three years, pemoline (Cylert®) has changed from an occasionally prescribed second order medication to a rarely prescribed long-acting stimulant medication because of reports of a rare and potentially lethal hepatotoxicity. The recommendation for frequent liver function blood tests is a further disincentive to prescription of this medication.



In this document, generic names of medications will also be matched with their more common brand names. Medication management is not a service provided in isolation from other interventions or instead of other interventions. Studies of combined medication management with intensive case management and additional psychosocial rehabilitation services document better intervention compliance and better outcomes. This guideline summarizes reviews of the major classes of medications used with child and adolescent mental disorders.

### A. PSYCHOSTIMULANTS

The medications of this class have similar side effects and safety. All have been in use in the US for more than twenty years. This class includes:

1. Methylphenidate, available as Ritalin® and numerous generic brand names,
2. Dextro-amphetamine, available as Dexedrine®, and mixed salts of dextro-amphetamine and inactive levo-amphetamine, available as Adderall® and
3. Pemoline, available as Cylert®.

The literature of over 160 replicated randomized controlled trials demonstrate robust short-time efficacy and a good safety profile when used for the symptoms of Attention Deficit Hyperactivity Disorder (ADHD); five of these studies were conducted in preschool age children. Few studies lasting longer than 24 months have been conducted which demonstrate longer-term efficacy. Side effects are manageable with monitoring, dose and timing adjustment and matching medication to the needs of the patient. Generally, patients continue to respond to the same dose over time without a need to increase the dose; there is little evidence for the development of tolerance. As most of these medications have rapid absorption and rapid metabolism, they are short in duration with onset of effect within 30 minutes, peak within one to three hours, and rarely have an effect beyond five hours. Thus, most patients require multiple doses and demonstrate some “roller-coaster” effect; some have a “rebound” effect with short-term intense “wear off” effects. These effects are related to the short duration of effect and account for much of the reported poor compliance with use as prescribed on a multiple-dosing schedule. A multiple dosing of schedule II controlled medications also complicates management in schools, leading to further problems with compliance. Thus, compliance with the multiple doses that produce improved school and home behavior and performance is a concern with these short-acting medications.

Stimulant-related adverse effects may occur early in intervention and are generally mild, short-lived, and responsive to dose and timing adjustments. Severe adverse effects, which necessitate discontinuation of medication, occur in less than 10% of patients. The most common adverse effects are delayed sleep onset, reduced appetite, stomachache, headache, and jitteriness. Rare side effects include perseverative behaviors, cognitive impairments, and motor and/or vocal tics, which usually respond to dose and timing adjustments. Hallucinations, psychotic reactions, and mood disturbance have been reported only in overdoses and in patients receiving high doses of stimulants.

Abuse is a concern, although emergency room reporting in the Drug Abuse Warning Network documents the prescription stimulant abuse rate at less than 1/40th of the rate for cocaine. Abusers generally prefer substances, which produce euphoria such as methamphetamine and cocaine. The majority of studies do not suggest that the use of prescribed stimulants for ADHD increases the risk of abuse.

Pemoline is the only stimulant that has a longer effect than the approximately five-hour effect described with methylphenidate and dextro-amphetamine. Long-term use of pemoline has been associated with rare, but increased, risk of hepatotoxicity, which has resulted in cautionary recommendations for frequent liver function testing as noted in the Introduction.

Methylphenidate has recently been released in a longer-acting product, Concerta®, which may improve compliance with stimulant medication.

In the NIMH Collaborative Multisite Multimodal Treatment Study (MTA) of children with ADHD, compliance was highest in the study group receiving monthly physician monitoring, school and family behavioral management training. Compliance studies with a variety of medications demonstrate improved compliance with less frequent dosing; once a day dosing produces the greatest rate of compliance.

Monitoring of stimulant medication includes observation and mental status monitoring as well as focused physical examinations with particular attention to movement disorders, tics, tremors, and a regular schedule of monitoring heart rate and blood pressure as well as stature and weight changes. After titration to an effective dose and timing schedule, monitoring can be reduced to less than five follow-ups per year, with parents and teachers aware of the medication and potential adverse effects. The regularity of schedule follow up is a factor in improving compliance. Parent and teacher completion of rating scales and school progress reports are important components of assessing the effects of stimulants and other interventions. Continuous performance testing may also be helpful in documenting changes in inattention, impulsivity, and distractibility related to medication dose and timing.

### **B. TRICYCLIC ANTIDEPRESSANTS**

The medications of this class have been in use for more than twenty years. Tricyclic antidepressants (TCAs) affect a number of neurotransmitter/receptor systems in the central nervous system, but their action is believed to be primarily based on effects on the serotonergic system. This class includes medications such as the following (not a complete listing), which are all available in generic form:

1. Imipramine (Tofranil®), the most-studied TCA,
2. Desipramine (Norpramin®),
3. Amitriptyline (Elavil®),
4. Nortriptyline (Pamelor®), and
5. Clomipramine (Anafranil®), a TCA with many specific studies related to obsessive-compulsive disorder.

Early research in child and adolescent mental disorders investigated imipramine in DBPC studies of efficacy with school phobia and separation anxiety; imipramine was superior to placebo in reducing anxiety and school refusal. Subsequent studies were conducted, investigating imipramine and desipramine for ADHD in comparisons with placebo, methylphenidate and clonidine in patients randomly assigned to intervention or placebo groups; imipramine and desipramine proved superior to placebo and variable in efficacy relative to methylphenidate, with all three active medications superior to placebo. Many other DBPC studies have been conducted with imipramine, desipramine, amitriptyline, and nortriptyline for efficacy with major depressive disorders; all of these TCAs studies demonstrated superiority to placebo in reducing depressive symptomatology.

Clomipramine has been investigated in DBPC and double-blind crossover studies for efficacy with obsessive-compulsive disorder, depression, and autistic disorder. Clomipramine had superior efficacy to placebo and to desipramine in four studies for depression and one study for ritualized, repetitive behaviors of autism. Many DBPC studies have demonstrated the efficacy of imipramine for control of nocturnal enuresis.

Despite demonstrable efficacy for a number of child and adolescent mental disorders in randomized controlled studies, concerns persist about the safety of these medications in children. Overdoses of these medications are potentially lethal. Cardiovascular adverse effects have been reported including rare reports of sudden death in youth treated with desipramine and imipramine. Similar arrhythmias have been noted with clomipramine including persistent tachycardia. Sweating, dry mouth, urinary

retention, and constipation are reported adverse effects with this class of medications. Psychiatric and medical complications can include serotonergic syndrome and induction of mania.

With the availability of a new generation of medications with potential efficacy in the same disorders and a much-decreased incidence of adverse reactions, these medications have become useful only after intervention failures or for specific contra-indications with other safer medications. These medications require careful monitoring for medical and psychiatric adverse reactions.

### **C. NONTRICYCLIC ANTIDEPRESSANTS**

This group includes medications with greater neurotransmitter and receptor specificity in the nervous system than the TCAs, which affect multiple neurotransmitters and receptor sites; with this greater specificity, fewer unwanted effects occur. This class includes:

1. Selective serotonin reuptake inhibitors (SSRIs - not a complete listing)
  - a. Fluoxetine (Prozac®),
  - b. Sertraline (Zoloft®),
  - c. Fluvoxamine (Luvox®),
  - d. Paroxetine (Paxil®)
  - e. Citalopram (Celexa®)
2. Other antidepressant medications, affecting alternative
  - a. neurotransmitter/receptor systems (partial listing)
  - b. Bupropion (Wellbutrin®)
  - c. Venlafaxine (Effexor®)
  - d. Nefazodone (Serzone®)
3. Monoamine oxidase inhibitors (MAOIs - partial listing)
  - a. Phenelzine (Nardil®)
  - b. Tranylcypromine (Parnate®)
  - c. Pargyline (Eutron®)

The SSRIs: the majority of the studies involve the efficacy of fluoxetine for the intervention of major depressive disorders. The data in double-blind, placebo-controlled studies support the effectiveness of SSRIs in the short-term intervention of relatively severe, persistent major depressive disorders in children and adolescents. Fluvoxamine and sertraline have been studied in DBPC studies involving children and adolescents with obsessive-compulsive disorder with demonstrated superiority in symptom reduction compared to placebo. Both are approved for the intervention of obsessive-compulsive disorder in children. A single DBPC study of fluoxetine supports effectiveness with selective mutism in children aged 5 to 14. For Tourette's disorder and ADHD, the data for effectiveness for SSRI intervention is mixed and lacks DBPC studies.

The second group including bupropion, venlafaxine and nefazodone are not impressive for child and adolescent patients with ADHD, depression, or anxiety in published studies. Almost all of these studies are small, open label, and lack controls, except for a single unreplicated DBPC study of bupropion demonstrating efficacy for ADHD.

The MAOIs: adult experience reserves the use of MAOIs to TCA-refractory severe psychiatric disorders in adults. These medications require careful attention to the avoidance of foods and medications containing the amino acid tyramine, which in combination with MAOIs may precipitate potentially lethal hypertensive crises. Newer MAOIs with reduced risk of food and medication interactions are under investigation in Europe. Only five limited studies of MAOI use in children have been published.

Few data are available on the safety of SSRIs, MAOIs, and bupropion, venlafaxine, and nefazadone in children and adolescents. Bupropion in high doses has been reported to increase the risk of seizures.

All of the currently available antidepressants have a risk of induction of mania. Many of the SSRIs and TCAs have a risk of the emergence of a serotonergic syndrome. In addition, there are concerns that efficacy studies in adults may not be appropriately generalized to children with differing metabolisms, differing presentations, and possibly differing etiologies for similarly presenting disorders.

### D. MOOD STABILIZERS

During the 1980s and 1990s, the efficacy of anticonvulsant mood stabilizers in adult bipolar disorder was demonstrated in multiple DBPC studies, adding these medications to lithium and antipsychotics as effective medications for bipolar disorder. The mood stabilizers include:

1. Lithium salts (Lithobid®, Eskalith®, Lithonate®)
2. Anticonvulsants
  - a. Carbamazepine (Tegretol®)
  - b. Valproate (Depakote® and Depakene®) and
  - c. Novel anticonvulsants including gabapentin (Neurontin®) and lamotrigine (Lamictal®)

These medications have been studied for use in treating bipolar disorder, conduct disorder, severe aggression, and ADHD.

**Lithium:** Lithium previously was the most commonly used FDA approved medication for bipolar disorder before the anticonvulsant mood stabilizing effect was demonstrated. Only a single lithium study appears which is DBPC and demonstrates efficacy of lithium with bipolar disorder in adolescents. The FDA has approved lithium for adolescents who are 12 or older for the indication of bipolar disorder. Lithium use requires lithium blood level monitoring and blood tests for renal and thyroid toxicity on a regular schedule. Overdose is potentially lethal.

**Carbamazepine (CBZ) and valproate:** There are two NIMH ongoing controlled studies of mood stabilizers in adolescents. Four DBPC studies on children and adolescents with aggression and conduct disorder have mixed results. Carbamazepine has been used for seizure disorders for many years and its safety and side effects are well documented. Common side effects include drowsiness, loss of coordination, and vertigo. Rarely, hematological, dermatological, hepatic, and pancreatic effects occur. The FDA labeling does not include approval for any psychiatric disorders although the adult literature has demonstrated its effectiveness for bipolar disorders in DBPC studies. Valproate also has a long history as an anticonvulsant with known side effects. Common side effects include sedation, nausea, blood dyscrasias, tremor, and weight gain. Rarely, hepatotoxicity has occurred in very young children, predominantly those under two years of age, who have seizures and other complex medical problems. Psychiatric use of valproate generally has not involved children this young. A metabolic syndrome with obesity, hyperinsulinism, lipid abnormalities, polycystic ovaries, and hyperandrogenism has been reported in women under 20 who have been treated with long-term valproate for seizures. Lithium, CBZ, and valproate require regularly scheduled and careful medical monitoring, blood levels, and laboratory tests for adverse effects.

**Novel anticonvulsants including gabapentin (Neurontin®) and lamotrigine (Lamictal®):** These medications lack data for efficacy in child and adolescent mental disorders in DBPC studies. Although there are many open trials and case studies presented in the literature and the disorders for which these medications are prescribed are considered severe, chronic, or intractable, insufficient data exist concerning both efficacy and safety.

### E. ANTIPSYCHOTICS

Antipsychotics are used in children and adolescents for psychotic disorders and a variety of more severe and intractable disorders including autism, Tourette's disorder, and disorders in the mentally retarded that include severe behavioral and mood disorders and psychosis. These medications include:

1. First generation antipsychotics (not a complete listing)
  - a. Haloperidol (Haldol®)
  - b. Chlorpromazine (Thorazine®)
  - c. Thiothixene (Navane®)
  - d. Pimozide (Orap®)
  - e. Thioridazine (Mellaril®)
2. Atypical antipsychotics (not a complete listing)
  - a. Clozapine (Clozaril®)
  - b. Risperidone (Risperidal®)
  - c. Olanzapine (Zyprexa®)
  - d. Quetiapine (Seroquel®)

Over 68 well-designed efficacy studies with DBPC and crossover studies comparing antipsychotics have been published.

**Autism:** Studies targeting stereotypies, self-injurious behaviors, aggression, temper tantrums, and hyperactivity have demonstrated the superiority of haloperidol over placebo in children from 2 to 8 years of age. Other open label medication trials are suggestive that other antipsychotics, including two of the atypical antipsychotics, have similar efficacy, but these studies lack the scientific rigor of the haloperidol studies.

**Schizophrenia:** Many well-designed studies confirm the superiority of haloperidol over placebo in adolescents with this disorder. A single DBPC study involving children from 5.5 to 11.75 years of age also demonstrated haloperidol superiority over placebo for controlling psychotic symptomatology. Other more limited studies have compared haloperidol with other first generation antipsychotics; haloperidol and the comparison antipsychotics were similarly effective and had similar side effects. Sedation and the development of Parkinson syndrome are the most common adverse effects; however, serious long-term and potentially irreversible extrapyramidal effects such as tardive and other dyskinesias remain a concern with the first generation antipsychotics. Generally, they are less effective with the negative signs of schizophrenia. Clozapine has been compared with haloperidol in a DBPC study involving adolescents and is superior to haloperidol on all measures of psychosis including negative signs. The incidence of extrapyramidal side effects is rare with clozapine; however, seizures, neutropenia, and other hematological complications are increased in incidence with clozapine use. Risperidone, another atypical antipsychotic with a similar profile to clozapine, is associated with a higher rate of extrapyramidal complications but fewer hematological complications. Weight gain and an increased risk of developing diabetes is a concern with most of the first generation and atypical antipsychotics.

**Tourette's disorder:** Three DBPC studies demonstrate superiority of antipsychotics over placebo for control of the motor and vocal tics of Tourette's disorder. Most of the published research on antipsychotic efficacy in Tourette's disorder involves either haloperidol or pimozide, both of which have similar efficacy. Pimozide, has, in addition to the above-noted adverse reactions, the potential for serious arrhythmias, which necessitate ECG monitoring before intervention, periodically during intervention, and at dose changes.

**Conduct disorder:** The use of an antipsychotic medication in the intervention of a conduct disordered youth is justified only in situations with co-occurring severe and intractable disorders such as psychosis

or Tourette's disorder that are not responsive to other interventions and medications with lower risk for adverse reactions. Haloperidol has demonstrated superiority over placebo in controlling the severe aggressiveness of some conduct-disordered youth in a DBPC study. Comparison with lithium: lithium has demonstrated a similar efficacy as haloperidol and superiority over placebo. Other first generation antipsychotics, including thioridazine and molidone have a similar efficacy reported in less rigorous studies.

**Mental Retardation:** Hyperactivity and aggressiveness respond moderately to haloperidol and thioridazine in DBPC studies. The haloperidol study patients were adolescent and older, and the thioridazine study included patients between 4.1 and 16.5 years with a mean age of 10.0 years.

**ADHD:** DBPC studies in the 1970s demonstrated superiority of chlorpromazine, haloperidol and thioridazine over placebo in controlling hyperactivity and aggression. In this age, the use of an antipsychotic in the intervention of ADHD is justified only in situations with co-occurring severe and intractable disorders such as psychosis or Tourette's disorder that are not responsive to other medications with lower risk for adverse reactions.

**Antipsychotics** have significant risks of adverse effects and require careful medical and psychiatric monitoring. A thoughtful risk/benefit analysis is appropriate and usually limits the use of these medications to intervention of specific severe and intractable disorders.

### F. ANXIOLYTICS AND OTHERS

Many other medications have been prescribed for child and adolescent mental disorders. Few DBPC studies are reported, but the scant information from the literature is summarized by various classes of medications.

1. Anxiolytics
  - a. benzodiazepines
  - b. Alprazolam (Xanax®)
  - c. Clonazepam (Klonopin®)
  - d. Diazepam (Valium®)
  - e. Midazolam (Hypnovel®)
2. 5-HT<sub>1A</sub> agonists  
Buspirone (Buspar®)
3.  $\beta$ -blockers
  - a. Propranolol (Inderal®)
  - b. Metoprolol (Lopressor®)
  - c. Nadolol (Corgard®)
4.  $\alpha$ -adrenergic agonists
  - a. Clonidine (Catapres®)
  - b. Guanfacine (Tenex®)
5. Opiate antagonists  
Naltrexone

Although benzodiazepines have been prescribed for children and adolescents, only clonazepam and alprazolam have been demonstrated to have superiority over placebo in DBPC studies for panic disorder and anxiety disorders. Anxiety associated with medical procedures responds to midazolam in DBPC studies; this medication is available only as a parenteral injection solution. Generally, these medications are safe and non-lethal even in overdose. The major side effects are drowsiness and sedation. In adults on long-term medication, there are concerns about the development of tolerance and dependency; this concern has not been adequately addressed in studies in children and adolescents.

Buspirone has been studied in open trials for anxiety, aggression, pervasive developmental disorders, and ADHD, but no DBPC studies have demonstrated efficacy for these or any other mental disorders of childhood or adolescence. Medications of this class are generally quite safe with only mild side effects of dizziness, stomachache, sedation, asthenia, or headache. There are no problems with withdrawal even after prolonged use.

The beta-blockers have been used for children and adolescents with anxiety and dyscontrol with aggression, but no systematic DBPC studies have been published. Adverse reactions include sedation, hypotension, bradycardia, and bronchoconstriction. There are reported concerns that growth hormone regulation may be disrupted, leading to over-release of growth hormone.

Clonidine and guanfacine are  $\alpha$ -adrenergic agonists that have been used to treat hypertension since the 1960s. Since the 1970s, these medications have been used in Tourette's disorder, ADHD, ADHD complicated by Tourette's disorder or motor tics, autistic disorder, aggression, and sleep disorders related to stimulant intervention. DBPC studies have produced inconsistent results with these disorders. Adverse effects include cardiac arrhythmias, particularly when these medications are used in combination with others medications. Sudden deaths have been reported in children receiving the combination of methylphenidate and clonidine. Less serious adverse effects include sedation and hypotension.

Naltrexone is an opiate antagonist. Four DBPC studies demonstrate superiority over placebo in reduction of hyperactivity associated with autism. No significant effect on reduction of self-injurious behavior has been substantiated. There are no long-term studies on the safety of naltrexone in children; adult use has been associated with hepatotoxicity in patients with a history of alcohol and drug abuse. Common mild side effects include drowsiness, anorexia, and vomiting. A single study on the use of naltrexone in Rett's disorder was associated with a more rapid decline in motor performance and a more rapid progression of the disorder in ten patients in the intervention group compared to a control group. Thus, the use of naltrexone is contraindicated in children with Rett's disorder.

## **XII. SUMMARY**

This set of guidelines is based on published literature reviews that are referenced below. The use of pediatric psychopharmacology should be guided by basic principles:

1. Medication decisions should be based on a careful diagnosis, an understanding of co-existing medical and mental disorders, consideration of potential interactions with other substances, and empirically based studies concerning efficacy and safety.
2. Most medications with established efficacy have known risks for adverse effects. Medication choices should be based on a careful risk/benefit analysis, weighing potential benefits against potential risks.
3. Medication effects and adverse effects should be monitored with data from multiple sources, including parents, teachers, school nurses, physical and neurological examination, mental status, and laboratory studies. Revise medication, doses, and scheduling of medication based on monitoring data.
4. When an empirically-based choice of medication appears to be ineffective, the team should reevaluate diagnosis, including co-existing disorders, doses and timing of doses, and medication compliance before considering an alternative medication or a combination of medication which lacks substantial empirical support for effectiveness or safety.
5. When involved in the intervention of severe and intractable mental disorders, an attitude of humility and honesty leads to better parental cooperation and understanding and to better outcomes. A second opinion with a colleague can be most helpful.

6. Studies that involve coordinated teams in combined psychosocial and medical interventions for the most complex disorders have generally resulted in better outcomes with improved compliance.
7. Intensive case management is the essential agent of change in complex mental disorders.



### XIII. REFERENCES FOR PSYCHOPHARMACOLOGY

1. NASMHPD Medical Directors Council and NASMD. Technical Report on Psychiatric Medications. Alexandria, VA: 2001.
2. Campbell M, Rapoport J, Simpson G. 1999. Antipsychotics in Children and Adolescents. *J Am Acad Child Adolesc Psychiatry* 38:537-545
3. Emslie G, Walkup J, Pliszka S, Ernst M. 1999. Nontricyclic Antidepressants: Current Trends in Children and Adolescents. *J Am Acad Child Adolesc Psychiatry* 38:517-528
4. Geller B, Reising D, Leonard H, Riddle M, Walsh T. 1999. Critical Review of Tricyclic Antidepressant Use in Children and Adolescents. *J Am Acad Child Adolesc Psychiatry* 38:513-516
5. Greenhill L, Halperin J, Abikoff H. 1999. Stimulant Medications. *J Am Acad Child Adolesc Psychiatry* 38:503-512
6. Jensen P, Bhatara V, Vitiello B, Hoagwood K, Feil M, Burke L. 1999. Psychoactive Medication Prescribing Practices for U.S. Children: Gaps Between Research and Clinical Practice. *J Am Acad Child Adolesc Psychiatry* 38:557-565
7. Riddle M, Bernstein G, Cook E, Leonard H, March J, Swanson J. 1999. Anxiolytics, Adrenergic Agents, and Naltrexone. *J Am Acad Child Adolesc Psychiatry* 38:546-556
8. Ryan N, Bhatara V, Perel J. 1999. Mood Stabilizers in Children and Adolescents. *J Am Acad Child Adolesc Psychiatry* 38:529-536
9. Vitiello B, Bhatara V, Jensen, P. 1999. Introduction: Current Knowledge and Unmet Needs in Pediatric Psychopharmacology. *J Am Acad Child Adolesc Psychiatry* 38:501-502

The preparation of this section of the CAMHD Practice Guidelines was greatly assisted by two publications of major reviews related to psychopharmacology:

1. The May 1999 Special Section of the Journal of the American Academy of Child and Adolescent Psychiatry on Current Knowledge and Unmet Needs in Pediatric Psychopharmacology, and
2. The February 2001 Technical Report on Psychiatric Medications, prepared by the National Association of State Mental Health Program Directors Medical Directors Council and the National Association of State Medicaid Directors, with funding provided by the Center for Mental Health Services of SAMHSA.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

**Table 1.**  
**Scientific Knowledge in Pediatric Psychopharmacology**

Category	Indication	Level of Supporting Data <sup>a</sup>			
		Short-Term Efficacy	Long-Term Efficacy	Short-Term Safety	Long-Term Safety
Stimulants	ADHD	A	B	A	A
SSRIs	Major depression	B	C	A	C
	OCD	A	C	A	C
	Anxiety disorders	C	C	C	C
Central adrenergic agonists	Tourette's disorder	B	C	B	C
	ADHD	C	C	C	C
Valproate and carbamazepine	Bipolar disorders	C	C	A <sup>b</sup>	A <sup>b</sup>
	Aggressive conduct	C	C	A	A <sup>b</sup>
TCAs	Major depression	C	C	B	B
	ADHD	B	C	B	B
Benzodiazepines	Anxiety disorders	C	C	C	C
Antipsychotics	Childhood schizophrenia & psychoses	B	C	C	B
	Tourette's disorder	A	C	B	B
Lithium	Bipolar disorders	B	C	B	C
	Aggressive conduct	B	C	C	C

*Note:* SSRI = selective serotonin reuptake inhibitor; TCA = tricyclic antidepressant; ADHD = attention-deficit hyperactivity disorder; OCD = obsessive compulsive disorder.

<sup>a</sup> A = adequate data to inform prescribing practices; for efficacy and short-term safety:  $\geq 2$  randomized controlled trials (RCTs) in youth; for long-term safety: epidemiological evidence and/or minimal adverse incident report to the Food and Drug Administration. B = for efficacy and short-term safety: 1 RCT in youth or mixed results from  $\geq 2$  RCTs. C = no controlled evidence.

<sup>b</sup> Safety data based on studies of children with seizure disorder.

**The table above is adapted with permission from Jensen et al. (1999), *Psychoactive Medication Prescribing Practices for U.S. Children: Gaps Between Research and Clinical Practice*, *Journal of the American Academy of Child and Adolescent Psychiatry*, 38: 557-565.**

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## Evidence-Based Child and Adolescent Psychosocial Interventions

This tool has been developed to guide teams (inclusive of youth, family, educators and mental health practitioners) in developing appropriate plans using psychosocial interventions. Teams should use this information to prioritize promising options. For specific details about these interventions and their applications (e.g., age setting, gender) see the most recent Evidence Based Services Committee Biennial Report (<http://www.hawaii.gov/health/mental-health/camhd/library/webs/ebs/ebs-index.html>).

Problem Area	Level 1- BEST SUPPORT	Level 2- GOOD SUPPORT	Level 3- MODERATE SUPPORT	Level 4- MINIMAL SUPPORT	Level 5- KNOWN RISKS
<b>Anxious or Avoidant Behaviors</b>	Cognitive Behavior Therapy (CBT); Exposure; Modeling	CBT with Parents; Group Cognitive Behavior Therapy; CBT for Child and Parent; Educational Support	None	Eye Movement Desensitization and Reprocessing (EMDR), Play Therapy, Individual (Supportive) Therapy; Group (Supportive) Therapy	None
<b>Attention and Hyperactivity Behaviors</b>	Behavior Therapy <sup>§</sup>	None	None	Biofeedback; Play Therapy, Individual or Group (Supportive) Therapy, Social Skills Training; "Parents are Teacher," Parent Effectiveness Training, Self-Control Training	None
<b>Autistic Spectrum Disorders</b>	None	None	Applied Behavior Analysis; Functional Communication Training; Caregiver Psychoeducation Program	Auditory Integration Training; Play Therapy, Individual or Group (Supportive) Therapy	None
<b>Bipolar Disorder</b>	None	Interpersonal and social rhythm therapy*	Family psychoeducational interventions*	All other psychosocial therapies	None
<b>Depressive or Withdrawn Behaviors</b>	CBT	CBT with Parents; Interpersonal Therapy (Manualized IPT-A); Relaxation	None	Behavioral Problem Solving, Family Therapy, Self-Control Training, Self-Modeling, and Individual (Supportive) Therapy	None
<b>Disruptive and Oppositional Behaviors</b>	Parent and Teacher Training; Parent Child Interaction Therapy	Anger Coping Therapy; Assertiveness Training; Problem Solving Skills Training, Rational Emotive Therapy, AC-SIT, PATHS and FAST Track Programs	Social Relations Training; Project Achieve	Client-Centered Therapy, Communication Skills, Goal Setting, Human Relations Therapy, Relationship Therapy, Relaxation, Stress Inoculation, Supportive Attention.	Group Therapy
<b>Eating Disorders</b>	CBT* (bulimia only)	Family Therapy (anorexia only)	None	Individual (Supportive) Therapy	Some Group Therapy
<b>Juvenile Sex Offenders</b>	None	None	Multisystemic Therapy***	Individual or Group (Supportive) Therapy	Group Therapy***
<b>Delinquency and Willful Misconduct Behavior</b>	None	Multisystemic Therapy; Functional Family Therapy	Multidimensional Treatment Foster Care, Wrap-Around Foster Care	Individual Therapy, Juvenile Justice System	Group Therapy
<b>Schizophrenia</b>	None	None	Behavioral Family Management*; Family-Based Intervention*; Personal Therapy*; Social Interventions*	Supportive Family Management*; Applied Family Management*	None
<b>Substance Use</b>	CBT**	Behavior Therapy; Purdue Brief Family Therapy	None	Individual or Group (Supportive) Therapy, Interactional Therapy, Family Drug Education, Conjoint Family Therapy, Strategic Structural Systems Engagement	Group Therapy

\* Based on findings with adults only; \*\* Appropriate if youth is in out of home setting, otherwise consider level 2; \*\*\* if delinquency and willful misconduct are present. § Consider medication or combined treatment as strongest options for hyperactivity only, or combined treatment as strongest for hyperactivity, academics (reading), and family interaction.

## Evidence-Based Child and Adolescent Psychopharmacology

This tool has been developed to guide teams (inclusive of youth, family, educators and mental health practitioners) in determining appropriate psychopharmacological treatment. Information summarized here was not reviewed at a level of detail to allow detailed inferences about medications within their medication classes. For example, although there might be support for one medication within a class (e.g., SSRIs), there might be minimal or no support for others within that same class. For these more specific decisions, it is advisable to seek additional information and input regarding appropriate medication use. For more details about these medications and their applications see the most recent EBS Committee Biennial Report (<http://www.hawaii.gov/health/mental-health/camhd/library/webs/ebs/ebs-index.html>).

PROBLEM AREA	MEDICATION	SHORT-TERM EFFICACY	LONG-TERM EFFICACY	SHORT-TERM SAFETY	LONG-TERM SAFETY
Anxiety Disorders	SSRIs	A	C	C	C
	Benzodiazepines	C	C	C	C
Obsessive-Compulsive Disorder	SSRIs	A	C	B	C
ADHD	Stimulants	A	B	A	A
	TCA's	B	C	B	B
	Central Adrenergic Agonists	C	C	C	C
Aggression in Autism	Antipsychotics	B	C	B	B
Aggressive Conduct	Lithium	B	C	B	C
	Valproate and Carbamazepine	C	C	A	A
Bipolar Disorder	Lithium	B	C	B	C
	Valproate and Carbamazepine	C	C	A	A
Depression	SSRIs	A	C	B	C
	TCA's	C	C	B	B
Schizophrenia (psychotic disorders)	Antipsychotics	B	C	C	C
Tourettes	Antipsychotics	A	C	C	C
	Central Adrenergic Agonists	B	C	B	C

Key: SSRI = Selective Serotonin Reuptake Inhibitor      TCA = Tricyclic Antidepressant

**A** = Adequate data to inform prescribing practices. For efficacy and short-term safety: 2 ≥ randomized controlled trials (RCT) in youth. For long-term safety: Epidemiological evidence and/or minimal adverse incident report to the Food and Drug Administration

**B** = For efficacy and short-term safety: 1 RCT in youth or mixed results from 2 ≥ RCTs.

**C** = No controlled evidence



***SECTION IV:***

**INTERAGENCY  
SERVICE INTENSITY GUIDELINES**

**CHANGING THE INTENSITY OF SUPPORTS AND SERVICES**

**DOE & DOH INTERAGENCY PROCEDURES**

## **SECTION IV: INTERAGENCY SERVICE INTENSITY GUIDELINES**

### **I. INTRODUCTION**

Quality assurance procedures within the DOE and DOH are multifaceted and multileveled. An integral part of the Child and Adolescent Mental Health Division (CAMHD) plan is the requirement for Mental Health Care Coordinators (MHCC) to review their cases regularly and, at least quarterly, report to their supervisor on the status. The DOE, through provisions of the Individuals with Disabilities in Education Act (IDEA), and through school and district Quality Assurance Plans, requires a similar periodic review of student progress on behavioral goals and objectives. A student's status may warrant review on a more frequent basis due to instability or change in the student's need for more or less complex or intense services. Continuous monitoring of student progress and effective team planning and participation will quickly identify the need for and promote quality programming for students at these critical decision making points.

On occasion, an appropriate student behavior support plan will require supports and interventions beyond the scope of school-based behavioral health services. Conversely, a student receiving services identified in a Coordinated Service Plan will not always require a high level of services provided by multiple state agencies. The purpose of this document is to set forth procedures and guidelines to assist stakeholder decision-making regarding changes in the level or intensity of supports needed by a student. In the past, these changes may have been referred to as change in the "Level of Care" provided by school based and community-based service providers.

Changes in the level of intensity and restrictiveness of services will involve staff from both the Departments of Education and Health. Meaningful participation by the appropriate representatives is critical to ensure appropriate decisions are made to support the educational, behavioral, and mental health needs of the student. This is necessary because the decision encompasses a number of professional disciplines and multiple federal and state statutes and regulations. An actual decision to change a student's behavior plan is the result of team decisions in an Individualized Education Program Meeting.

### **A. PROCEDURES**

1. Either the MHCC or DOE CC (or school's designee) may request an interdepartmental staff discussion. Some schools have regularly scheduled student support or review meetings to discuss student status on an ongoing basis. If these meetings involve DOE and DOH personnel, these discussions are likely to occur in this venue.
2. A discussion is requested based upon the following:
  - a. A student's progress indicates that a more restrictive or intensive level of service or support is no longer needed.
  - b. A student's need for support indicates that a more restrictive or intensive level of service or support may be necessary.
  - c. The student's parent(s), guardian, or surrogate parent requests a change in the level of service or support.
3. The purpose of the discussion is to assure that there is adequate information available to the IEP team meeting to determine the following:
  - a. If a change in the level of service or support is appropriate.
  - b. What new level of service or support is now appropriate.
4. The attached team guidelines, as well as a continual perspective that is child-centered and family-focused, are an important starting point for all team discussions.

### **B. SCHEDULING**

The discussion to consider whether a child needs more or less intensive services should be scheduled at least two weeks prior to any IEP meeting in which a change in level of intensity is considered. The meeting should be scheduled to ensure that additional information is obtained or adequate research regarding the provision of the anticipated level of service is available to the IEP team. It is in the IEP team meeting that the actual decision regarding the needed services and supports is reached.

This does not mean that a properly convened IEP meeting that is in process should be halted if the need for change in a behavior plan surfaces as a topic for discussion nor should the need to have a “Staffing” be used to cause a delay in scheduling an IEP meeting to address a student’s recognizable need for an increase in support. In the event that a student’s level of service intensity is changed through an IEP meeting without an interagency staff discussion, it is an indicator that either or both departments should institute a Peer Review to determine a need for corrective action.

### **C. WHO SHOULD ATTEND**

Any and all department representatives necessary to establish the need for change should attend a discussion about the need for change in a student’s behavior plan. The need for change should be based on providing adequate answers to questions designed to (1) determine if a change in intensity of supports may be appropriate and (2) to assess what information will be necessary in developing a new plan that includes more or less intense behavior supports or services. In most cases it will require the CAMHD MHCC, DOE CC (or designee), and the relevant DOE staff. In situations involving complex student needs the Branch Chief and District SBBH staff may also need to attend.

### **D. REVIEW PROCESS**

Review the questions associated with more intensive service needs for students experiencing behavioral and/or emotional challenges. The questions are categorized around 1) school-based supports 2) intensive community-based services and 3) out of home services.

### **E. RELATIONSHIP TO CARE COORDINATION RESPONSIBILITIES**

The determination of the intensity of supports a student receives is made independently of which agency has, or may have, care coordination responsibilities. A change in care coordination will follow and be based on the student’s progress or need for change in intensity of support. The change will be done according to established agency criteria for the provision of care coordination.

### **F. RELATIONSHIP TO OTHER SUPPORT SERVICES**

In all situations, the determination of the intensity and type of supports provided students is made based on a student’s Behavior Support Plan (BSP) stemming from a Functional Behavioral Assessment (FBA) of the student’s Behavior. Significant change in progress or need leading to changes in the intensity of supports may require the addition or deletion of more than one type of support. When this occurs, the discussion must clearly identify where the responsibility for support lies and the relationship of each support to the other supports and its basis in the student’s BSP.



### II. SCHOOL BASED BEHAVIOR SUPPORT SERVICES FOR EMOTIONALLY AND/OR BEHAVIORALLY DISRUPTIVE YOUTH

If the IEP or MP Team determines that a student's behavior is interfering with his/her learning, the team shall review the following items in determining whether school based behavior services are needed:

1. The student has been evaluated and determined to be eligible for related service under IDEA / Chap 56 or section 504 / Chap 53.
2. The student's IEP/MP includes a comprehensive Behavior Support Plan (BSP). (If the student does not yet have an IEP/MP but is found eligible, the student's comprehensive behavior support plan will be developed.)
3. The behavioral goals and objectives are stated in specific, observable, and measurable terms.
4. The IEP/MP includes a plan to support staff (and parents as appropriate) in implementation of instructional interventions and contextual modifications (i.e., the plan ensures each participant has or will develop the resources, skills, and competencies needed to implement the BSP.)
5. The student has been provided instruction at his/her level and rate of understanding.
6. Parents are engaged as team members.

### III. INTENSIVE COMMUNITY-BASED MENTAL HEALTH SERVICES FOR EMOTIONALLY AND/OR BEHAVIORALLY DISRUPTIVE YOUTH

If additional supports appear to be needed beyond those that have been attempted, the team shall review the following discussion points prior to initiating services:

1. The IEP is current, and is being implemented consistently. It is evident that appropriate adjustments to the IEP have been made as warranted.
2. The goals and objectives as written on the IEP have been reviewed and are appropriate the youth's ability.
3. The team is clear about the reasons for lack of progress or regression. Data is available to support the concerns.
4. Parents are engaged as members of the team.
5. A Functional Behavioral Assessment (FBA) has been completed, and a comprehensive Behavioral Support Plan (BSP) is in place. The goals and objectives as written on the BSP have been reviewed. The time period that supports have been in place have been reviewed and adjustments have been made to the plan based on new information as appropriate.
6. The core issues of the student are understood. There is a long-term view of the goals of the student
7. The IEP team believes that the student requires more support to be maintained within the current classroom environment. The rationale for this has been outlined based on what has been learned through the FBA and BSP reviews and adjustments.
8. The team has identified the evidenced-based treatment interventions to be implemented. If not, why not? The evidence-based interventions will be applied with quality and consistency. The results of these interventions will be reviewed on a regular basis.
9. The team identified quarterly objective measures and a schedule for review of the supports and services being implemented.
10. There is an Emotional Behavioral Assessment or Psychiatric Diagnostic Evaluation with recommendation that the team is implementing.

### IV. OUT OF HOME MENTAL HEALTH TREATMENT SERVICES FOR EMOTIONALLY AND/OR BEHAVIORALLY DISRUPTIVE YOUTH

If the team believes out of home services may be warranted for a youth, the MHCC shall request clinical consultation from their supervisor and Clinical Director, as well as request an intensive behavioral consultation. The team should consider the following items before seeking consultative supervision.

1. The IEP/MP and CSP are current. The plans are being implemented with consistency and quality. The goals and objectives as written on these plans have been reviewed. If progress is not occurring, the team is clear about the reason(s), and appropriate adjustments are being made.
2. The Parents are engaged as team members.
3. The team has identified the underlying/core issue(s) involved.
4. The CAFAS has been conducted and the graph is available for review.
5. The Achenbach CBCL has been completed and is available for review.
6. A Functional Behavioral Assessment (FBA) has been completed and Behavioral Support Plan (BSP) is in place. The time period that supports have been in place have been reviewed as well as the modifications and adjustments to the plan.
7. The team has defined specific measurable goals that are to be addressed in the out of home service.
8. The team has described the supports that will be necessary to return the youth back home. There is a clear transition plan outlined to build on the progress made within the out of home service.
9. The team has identified the evidenced-based interventions to be implemented. If not, why not? The evidenced-based interventions will be applied with quality and consistency. The results of these interventions will be reviewed regularly.
10. There is a clear long-term view of the supports/services needed.
11. Ensure that there is an existing Emotional Behavioral Assessment or Psychiatric Diagnostic Evaluation with recommendation that the team is implementing.

***SECTION V:***

**GLOSSARY**

### **AACAP**

American Academy of Child & Adolescent Psychiatry.

### **Access to Services**

To ensure access to needed services, CAMHD's Policy and Procedure 80.614 Consumer Access to Services stipulates that (1) upon admission into a mental health treatment program, a youth remains in treatment until clinically discharged by the treatment team. If there are difficulties managing the youth's behavior, strategies are adjusted to meet the youth's needs, or a functional behavioral assessment is conducted and positive behavior support plan is developed and 2) that contracted service providers must accept all CAMHD youth referred to them by as long as the level of care is appropriate for youth's needs

### **Accreditation**

Authorization granted by the Hawaii State Department of Health for a non-governmental program to provide mental health services to children and/or youth as a result of demonstrated compliance with the standards established to provide such services (see section 321-193 (10), HRS (Hawaii Revised Statutes). Also, a designation conferred by any one of several national professional organizations, indicating that the Hawaii State Department of Health/Child and Adolescent Mental Health Division or Contractor has met high professional standards for the provision of mental health services to youth. Accrediting bodies relevant to CAMHD include the Council on Accreditation (COA), the Council on Accreditation of Rehabilitation Facilities (CARF), and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

### **Accreditation Council on Graduate Medical Education (ACGME)**

A professional entity that establishes national standards for graduate medical education and that assesses and approves educational programs under its aegis.

### **Achenbach System of Empirically Based Assessment (ASEBA)**

Instruments designed to gather information from multiple informants to help with assessment. The ASEBA school-age forms are a set that includes the Child Behavior Check List (CBCL), Teacher Report Form (TRF) and Youth Self Report (YSR) (see below)

### **Action**

The denial or limited authorization of a requested service or the reduction or the suspension or termination of a previously authorized service or the denial of payment for a service or the failure to provide services in a timely manner.

### **Action Letter**

The letter written to the consumer and/or parent/legal guardian when an action is going to be taken that is within a CAMHD authorization period. The purpose of the Action letter is to give the advance notice so that the action may be appealed.

### **Active Waitlist**

The active waitlist (also known as Category 1 Waitlist) is CAMHD youth, accepted for out-of-home services by contractors, who are ready to go into placement today.

**ADIS-IV** - See Anxiety Disorders Interview Schedule Child/Parent Version.

### **Adjunctive Therapy**

A specialized service to an existing therapy program that meets a need not fulfilled by the existing service.

### **Advanced Practice Registered Nurse (APRN)**

A professional designation indicating a high level of expertise in the assessment, diagnosis, and treatment of complex responses of individuals, families, or communities to actual or potential health problems, prevention of illness and injury, maintenance of wellness, and provision of comfort. The APRN holds a master's or doctoral degree in a specific area of advanced nursing practice, received supervised practice during graduate education, and has ongoing clinical experience. APRNs continue to perform many of the same interventions used in basic nursing practice but they have a greater depth of knowledge and a higher skill level than non-APRN nurses. APRNs include clinical nurse specialists, nurse practitioners, nurse anesthetists, and nurse-midwives.

### **Agency Aggregated Data Form**

A quarterly reporting form that summarizes the specific data sets of the Agency Quality Indicator Data Collection Tool. This form is part of the required Quarterly Quality Assurance Summary Report that is reviewed by CAMHD 's Performance Management office.

### **American Board of Medical Specialties**

A non-profit organization that comprised of and oversees physician certification of 24 medical specialty boards, including American Board of Psychiatry and Neurology.

### **American Board of Psychiatry and Neurology (ABPN)**

An independent, non-profit organization that certifies doctors practicing psychiatry and neurology and certifies individuals in subspecialties of those areas of practice including General Psychiatry and Child and Adolescent Psychiatry.

### **American with Disabilities Act (ADA)**

A federal Act that gives civil rights protections to individuals with disabilities, similar to the rights provided to individuals on the basis of race, color, sex, national origin, age, and religion. The ADA guarantees equal opportunity for individuals with disabilities in public accommodations, employment, transportation, State and local government services, and in telecommunications.

### **Anxiety Disorders Interview Schedule Child/Parent Version (ADIS-IV).**

The Anxiety Disorders Interview Schedule Child/Parent Version (ADIS-IV) is a structured interview assessment to aid in the diagnosis and assessment of anxiety disorders in children and adolescents.

### **Appeal**

A request for a review of an action. An action is defined as the denial or limited authorization of a requested service or the reduction or the suspension or termination of a previously authorized service or the denial of payment for a service or the failure to provide services in a timely manner.

**APRN** – See Advanced Practice Registered Nurse

**ASEBA** - See, Achenbach System of Empirically Based Assessment

### **ASEBA Child Behavior Check List (CBCL)**

A standardized child behavior checklist completed by the primary caretaker(s), scored and interpreted by an evaluator.

### **ASEBA Teacher Report Form (TRF)**

A standardized child behavior checklist completed by the primary teacher(s), scored and interpreted by an evaluator.

### **ASEBA Youth Self-Report (YSR)**

A standardized youth behavior checklist completed by youth aged 11 to 18, scored and interpreted by an evaluator.

### **Assessments**

- Emotional Behavioral Assessment (EBA) – assessment by DOE that diagnoses a student’s presenting symptoms so that the most effective interventions can be applied.
- Functional Behavioral Assessment (FBA) – assessment by DOE that culminates in the Behavior Support Plan (BSP)
- Comprehensive Mental Health Assessment – Strengths based approach that includes assessment and a written report. Assessment done by or contracted out by CAMHD that determines eligibility for the SEBD program and provides clinical information that assists with treatment planning and coordination of services
- Focused Mental Health Assessment – Strengths based approach that includes assessment and a written report. Done by CAMHD contractors to clarify diagnoses and treatment issues or when there is a lack of progress or when the level of care is being changed.
- Summary Annual Mental Health Assessment – Strengths based approach that includes assessment and a written report. Done by CAMHD contractors annually to capture the current status of the youth and his or her circumstances.

### **Attending Physician**

The physician who is primarily responsible for a client’s care.

### **Authorization**

CAMHD and DOE staff approval for procurement of provider agency service units based on interventions specified in a youth’s IEP/MP and CSP, as indicated.

### **Axis I Diagnosis**

Clinical Disorders defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM).

### **Axis II Diagnosis**

Personality Disorders and Mental Retardation as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).

### **Background Check**

State of Hawaii criminal history and child abuse and neglect clearances required to be credentialed by CAMHD.

### **Behavior Assessment System for Children, Second Edition (BASC-2)**

A comprehensive system for measuring behavior and emotion. It consists of a comprehensive set of rating scales and forms including the Teacher Rating Scales (TRS), Parent Rating Scales (PRS), Self-Report of Personality (SRP), Student Observation System (SOS), and Structured Developmental History (SDH). Together, they help in understanding the behaviors and emotions of children and adolescents.

### **Bed Hold**

A space reserved and paid for by CAMHD in an out-of-home treatment program for a youth who is absent from that program for more than 24 hours but who is expected to return to that program within a predetermined amount of time. Examples include youth who runaway or are temporarily in Acute Psychiatric Hospitalization, Community Hospital Crisis Stabilization, Community-Based Crisis Group Home, Hawaii Youth Correctional Facility or Detention Home. Bed holds are reimbursed at 50% of the contracted rate and may be used with prior written service authorization for up to seven (7) consecutive days within a single episode of care from the appropriate CAMHD FGC. Contractors are required to take youth back into their programs if a bed hold has been authorized by the Family Guidance Center unless an independent evaluation determines that an alternate service is necessary.

### **Behavioral Support Plan (BSP)**

A plan specifying support services for a youth that emanates from the functional assessment of that person's behavior, detailing the antecedent management, teaching, and consequence strategies designed to mediate specific challenging behavior in a specific individual. The plan should include ecological (environmental, dynamic, goodness of fit), communication and social skills interventions as well as molar (global) interventions such as social network interventions where applicable.

### **Best Practice**

Those strategies or interventions that have the highest evidence base (see "evidence-based" herein) supporting their positive effects for a particular problem and context. For example, for some problems and contexts, there might be multiple "evidence-based" interventions from which to choose. The principle of "best practice" would dictate choosing the approach that demonstrates the greatest promise for positive outcomes given the ranking of the evidence. Thus, an "empirically-supported" approach (see "empirically supported" herein) would usually be the choice over another "evidence-based" approach and would be preferred to a non-evidence-based approach. In the absence of any evidence for a particular problem and context, "best practice" would then refer to those strategies that draw from the strongest professional consensus. The principle of "best practice" does not confine practice choices or dictate a list of approved interventions, but rather requires one to start with the strongest sources of evidence as the principle guide to selecting and designing interventions for youth.



**BSP** - See, Behavioral Support Plan

**CAFAS** - See, Child and Adolescent Functional Assessment Scale

### **CALOCUS**

The CALOCUS (older version of the CASII) is a tool to determine the appropriate level of care placement for a child or adolescent. The CALOCUS links a clinical assessment with standardized “levels of care” and has a method for matching the two.

### **CAMHD**

The Child and Adolescent Mental Health Division of the Department of Health.

### **CAMHD Branch (a.k.a. Branch)**

Any of the seven Department of Health regional centers and the Family Court Liaison Branch that utilize CAMHD treatment teams to determine needed services and care coordinators to coordinate and procure services for youth in need of intensive mental health services.

### **CAMHD Clinician**

A CAMHD employee who is credentialed as a Mental Health Professional or Qualified Mental Health Professional.

**CARF** - See, Commission on Accreditation of Rehabilitative Facilities

### **Case Review**

Case review is a clinical review of individual youth status and treatment progress, which includes assessing sentinel events, progress toward goal attainment and the effectiveness of current treatment strategies. The purpose of the case review is to ensure that treatment plans are monitored and adjusted backed upon the results gained from data that has been gathered and used to measure change from a baseline reference point for each treatment goal.

### **Case Management**

Coordinating the provision of mental health services for children and their families who require services from more than one public or private provider.

**CASII** - See, Child and Adolescent Service Intensity Index.

**CASSP** - See, Child and Adolescent Service System Program

### **Category One (1) Waitlist**

CAMHD youth, accepted for out-of-home services by contractors, who are ready to go into placement today (also see Active Waitlist).

**CBCL** - See, ASEBA Child Behavior Check List (CBCL)

**CBR** - See, Community-Based Residential

### **Centers for Medicare and Medicaid Services (CMS) Accreditation**

CMS is the federal agency that administers the Medicare Program and partners with states to administer the Medicaid program. CMS issues standards that must be met by all facilities funded by Medicaid. More information about relevant standards is available on the website: [www.cms.hhs.gov](http://www.cms.hhs.gov).

### **Certified Substance Abuse Counselor (CSAC)**

A professional designation conferred by the State of Hawaii Department of Health/Alcohol & Drug Abuse Division, indicating an individual has successfully completed three years of clinically supervised experience in the area of substance abuse and has successfully completed a certificate program in substance abuse at the Associates degree level.

### **Chemical Restraint**

Any drug that is administered to manage a youth's behavior in such a way that reduces the safety risk to the youth or others or has the temporary effect of restricting the youth's freedom of movement and is not a standard treatment for the youth's medical or psychiatric condition.

### **Child Abuse and Neglect Check**

A query of the Department of Human Services Child Protective Services database system for history of or information about child abuse and neglect.

### **Child Abuse and Neglect Clearance**

State of Hawaii, Department of Human Services, Child Protective Services abuse history clearances required to be credentialed by CAMHD.

### **Child Abuse and Neglect Screening**

Nature, frequency and findings of found history of abuse are examined for potential risk factors that may preclude an applicant's serving a child or youth.

### **Child and Adolescent Functional Assessment Scale (CAFAS)**

The CAFAS is a rating scale that assesses a youth's degree of impairment in day-to-day functioning due to emotional, behavioral, psychological, psychiatric, or substance use problems. It is rated on youth aged 6-17 years and is used to track clinical outcomes, to assign youth to appropriate levels of care and as part of the criteria used to determine a youth's eligibility for CAMHD's SEBD program.

### **Child and Adolescent Service Intensity Index (CASII)**

The CASII (formerly called CALOCUS) is a tool to determine the appropriate level of care placement for a child or adolescent. The CASII links a clinical assessment with standardized "levels of care" and has a method for matching the two.

### **Child and Adolescent Service System Program (CASSP)**

A program established by Congress in 1984 to improve the way in which children and adolescents with or at risk of developing serious emotional or mental disorders and their families are offered multi-agency services. The core values of CASSP are that services be 1) child and family centered, 2) community-based, and 3) culturally competent. The guiding principles of CASSP are to provide 1) access to an array of services, 2) individualized services, 3) least restrictive environment, 4) full family participation, 5) integrated services, 6) care coordination, 7) early identification and intervention, 8) smooth transitions, 9) protection of the rights of the child, and 10) non-discrimination and cultural appropriateness.

### **Childcare Worker**

A paraprofessional supervised by a mental health professional or qualified mental health professional who assists that professional in providing direct care mental health services to youth. Also see "paraprofessional". (See Section I General Standards for qualification requirements).

### **Children's Interview for Psychiatric Syndromes (CHIPS),**

The Children's Interview for Psychiatric Syndromes (CHIPS) is a highly structured diagnostic interview designed to detect 20 frequently encountered psychiatric disorders and behavioral problems in children and adolescents 6 to 18 years of age. There is both a child self-report and a parent report version.

### **Clinical Note / Supervision Note**

A summary of a clinical supervision session that includes the date, duration, attendees, name and credentials of supervisor and summary of the content of the session

### **Clinical Supervision**

Regularly scheduled assistance given by a Mental Health Professional or Qualified Mental Health Professional to a staff member who is providing direct, therapeutic intervention to a youth. Clinical supervision is provided to insure that each youth receives appropriate treatment consistent with his/her needs and with accepted standards of practice. Clinical supervision is held face-to-face in an individual or group setting for requirements described in Section I General Standards unless otherwise specified and is documented by a clinical note placed in the supervised staff member's personnel file.

**CMS** - See, Centers for Medicare and Medicaid Services (CMS) Accreditation

**COA, Council on Accreditation** - See, Accreditation

**Commission on Accreditation of Rehabilitative Facilities (CARF)** - See Accreditation.

### **Community-Based Residential (CBR)**

An out-of-home placement for a high risk youth that is located in a local community and that provides 24-hour care and integrated service planning to address the behavioral, emotional and/or family problems that prevent the youth from taking part in family and/or community life.

### **Community Children's Council Office (CCCO)**

The organizational and resource foundation for community participation in the child and adolescent mental health system of care in Hawaii. The CCCO coordinates and supports the work of the regional Community Children's Councils throughout the State.

### **Comprehensive Student Support System (CSSS)**

Is a system of support, which provides an array of student support services available at the school, complex and state level in the five levels of student support. The CSSS array of student support services ensures that the supports provided and the delivery process correspond to the severity, complexity, and frequency of each student's needs. Each level increases in intensity of specialization of service.

### **Continuity of Care**

Provision and continuation of services such that youth are prepared for transition and there are no gaps in services between transitions in the CAMHD service array.

### **Contractor**

Organization or individual who is has a written contract or memorandum of agreement with CAMHD or Doe to provide behavioral/mental health services. May also be referred to as Provider or Contracted Provider

### **Contracted Provider**

Organization or individual who is has a written contract or memorandum of agreement with CAMHD or Doe to provide behavioral/mental health services. May also be referred to as Provider or Contracted Provider

### **Co-Occurring Disorder**

As used in these guidelines, refers to simultaneous behavioral health and substance abuse diagnoses for a given individual or simultaneous behavioral health and mild/moderate retardation, simultaneous behavioral health and developmental disorder or simultaneous behavioral health and a medical issue (e.g. blindness, deafness, medical problem).

### **Coordinated Service Plan (CSP)**

A written design for service that describes the roles and responsibilities of multiple agencies or programs that provides therapeutic or supportive interventions or activities essential to the youth and family's treatment.

### **Coordinated Service Planning Process**

A process of bringing together the family, multiple agencies and providers, and the child/youth, when appropriate, to develop a comprehensive and integrated plan of individualized care for the child/youth that is based on the child's/youth's strengths and needs.

### **Corrective Action Plan**

Corrective Action Plans or Improvement Plans are the result of CAMHD's systematic quality monitoring of services. CAMHD takes immediate corrective actions to remediate problems that are severely inappropriate, substandard or harmful to youth. Improvement plans are called for when the need for improvements are of a routine or less severe nature. Plans submitted to CAMHD shall specify the nature of the problem, the authorized person held accountable, the specific actions that will be implemented, the method of communications and feedback among affected persons, the schedule of tasks to be completed with due dates and persons responsible, and alternative action plans if improvements do not occur.

**Council on Accreditation (COA)** - See, Accreditation

### **Credentialing**

The review and approval of qualifications and other relevant information pertaining to a health care professional who provides direct services to CAMHD (includes DOE) youth.

### **Criminal History Check (a.k.a. Screening)**

State of Hawaii criminal history clearances required to be credentialed by CAMHD.

### **Criminal History Record Check**

A query of the Hawaii Justice Data Center database for criminal records.

### **Crisis Plan**

A plan to avert potential crises with specific, appropriate strategies to manage situations without placement disruption. The crisis plan includes persons to contact in case of an emergency and other specific action plans that must include the involvement of the agency's clinical, professional staff.

**CSAC** - See, Certified Substance Abuse Counselor (CSAC)

**CSP** - See, Coordinated Service Plan

**CSSS** - See, Comprehensive Student Support System

### **Department of Education (DOE)**

A State agency responsible for a "public school system that holds high expectations of what students should know, be able to do and care about . . . focuses attention, effort and resources on promoting student learning . . . holds each school accountable for meeting high standards of performance . . ."

### **Department of Health (DOH)**

A State agency that provides the leadership to monitor, promote, protect, and enhance the health and environmental well being of all of Hawaii's people.

### **Designee**

A professional staff person with professional credentials equivalent to the person for whom they are substituting and familiarity with the client about whom they are reporting.

### **Diagnostic Interview Schedule for Children (DISC)**

The NIMH *Diagnostic Interview Schedule for Children* is a highly structured interview designed to assess DSM-IV psychiatric disorders and symptoms in children and adolescents aged 6 to 17 years. The DISC was designed to be given by lay interviewers for epidemiological research. It has a parent and a child version, both of which ask about the child's psychiatric symptoms. The interview can be administered using a laptop computer (Computerized DISC, or CDISC).

### **Direct Care Staff**

Any person who provides face-to-face treatment, care, supervision, and/or other services for a youth, in support of that youth's individual service plan or treatment plan.

**DISC** - See, Diagnostic Interview Schedule for Children

### **Discharge Plan**

A plan specifying the process and the supports and services necessary for a successful and smooth transition from a youth's active involvement with a mental health service. A discharge plan is a required component of a youth's treatment plan that is created when the youth is admitted to a program and is reviewed and revised as needed on a regular basis by the youth's treatment team. (See also Transition Plan, Exit Plan)

### **Discharge Summary**

A written report by a qualified professional involved in the youth's treatment that states the duration of treatment, youth's adjustment, significant problems, accomplishments, youth status and other salient points of treatment progress and the outcomes and recommendations for any further mental health interventions needed.

**DOE** - See, Department of Education

### **DOE Diagnostic Packet**

A report from the Department of Education on a given student that includes a social history, educational assessment, speech/language evaluation, intellectual test and other related educational information.

**DOH** - See, Department of Health

### **Domain**

An area of a youth's life. Domains considered in developing a service plan for a youth are Family, School, Community, Individual, Social/Peer and Legal.

### **DRO**

Differential Reinforcement of Other Behavior or Ignoring is an intervention strategy that involves the training of parents or other involved in the social ecology of the child to selectively ignore mild target behaviors and selectively attend to alternative behaviors.

### **DSM Diagnosis**

Diagnosis obtained according to the criteria in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV).

### **Early Periodic Screening, Diagnosis and Treatment (EPSDT)**

EPSDT is a federally mandated program for children up to age 21 which emphasizes the importance of prevention through early screening for medical, dental and behavioral health conditions and timely treatment of conditions that are detected.

### **Elopement**

Running away; absent without permission; failure to return from authorized or permitted leaves.

### **Emergency Safety Intervention**

Intervention or action performed in a manner that is safe, proportionate, appropriate to the severity of the behavior and the youth's chronological and developmental age, size, gender, physical, medical, psychiatric condition and personal history (including any history of physical or sexual abuse) to ensure the safety of the youth and others.

### **Empirically-Supported**

A specific term that refers to a subset of "evidence-based" techniques (see "Evidence-Based" in this Glossary) that have met a particular set of more demanding criteria for their support and use as mental health treatments. These criteria were outlined nationally by the American Psychological Association Task Force on Psychological Intervention Guidelines (1995) and have been adapted locally by CAMHD (Multi Agency then Evidence- Based Services Committee). The two criteria that distinguish "empirically-supported" from other "evidence-based" techniques are: 1) efficacy, or how well a treatment is known to bring about change in the problem, and 2) effectiveness, or the clinical utility of the intervention. Whereas efficacy is mainly concerned with the quality of treatment in controlled, often university-based programs, effectiveness refers to the expected or observed performance of a treatment in a "real world" setting.

### **Episode of Care**

The time period between admission and discharge for any level of care.

**EPSDT** - See, Early Periodic Screening, Diagnosis and Treatment (EPSDT)

**ESY** - See, Extended School Year (ESY) Services

### **Evidence-Based**

Those strategies and interventions for which credible, published research exists demonstrating positive effects, including uncontrolled, open trials or case studies. For the purposes of the Evidence-Based Services Committee, such evidence is typically found in peer-reviewed scientific journals. The Evidence-Based Services Committee defines what constitutes evidence-based services for the purpose of these standards.

### **Evidence- Based Services Committee**

An interagency committee sponsored by CAMHD that reviews published research and commentary related to behavioral health services and prepares summary statements on evidence-based and best practices to guide local practice policies and standards.

**Exit Plan** – see transition plan, discharge plan.

### **Extended School Year (ESY) Services**

ESY services means special education and related services that are provided to a student with a disability beyond the normal school year of the school the student attends or will attend; in accordance with the student's IEP and at no cost to the parent of the student and meet the standards of the Department of Education. ESY services are available as necessary to provide a free appropriate public education and extended school year services shall be provided only if the student's IEP team determines that the services are necessary. In determining if a student with a disability needs ESY services, the IEP team considers the nature and severity of the student's disabling condition, the areas of learning crucial to attaining self sufficiency; the extent of regression caused by the interruption of educational programming and the rate of recoupment following interruption of educational programming.

### **Family Educational Rights and Privacy Act (FERPA)**

FERPA is a Federal law that protects the privacy of student education records. The law applies to all schools that receive applicable U.S. Department of Education funds. FERPA gives parents certain rights with respect to their children's educational records. These rights transfer to the student when he or she reaches the age of 18 or attends a school beyond the high school level. Students to whom the rights have transferred are "eligible students".

### **Family Guidance Center (FGC)**

Any of the seven Department of Health regional centers that utilize CAMHD treatment teams to determine needed services and care coordinators to coordinate and procure services for youth in need of intensive mental health services. .

### **Family of Origin**

The family into which a youth was born or the family that adopted the youth.

### **Family Therapy**

Regularly scheduled, individual, face-to-face therapeutic services for youth and at least one family member (biological family or foster family) designed to increase effective coping strategies, healthy communication, constructive problem-solving skills that may also include psycho-education.



**FAPE** - See, Free Appropriate Public Education

**FBA** - See, Functional Behavioral Assessment

### **Felix Consent Decree (FCD)**

A 1994 ruling (Felix v. Cayetano Consent Decree) from the U.S. District Court for Hawaii stating that "qualified handicapped children" in Hawaii were not receiving mental health services necessary to enable them to benefit from their education, and requiring the State Department of Education and State Department of Health to come into compliance with the Individuals with Disabilities Education Act (IDEA) and Section 504 of the Vocational Rehabilitation Act. Hawaii was found to be in compliance and exited this consent decree in 2005.

**FERPA** - See, Family Educational Rights and Privacy Act (FERPA)

**FGC** - See, Family Guidance Center

### **First Aid**

Emergency care given immediately to an injured person to minimize injury and future disability. Types of First Aid certification include: Standard First Aid; Standard First Aid with Cardiopulmonary Resuscitation (CPR)/Automated External Defibrillator (AED); and CPR-Adult Infant and Child

### **Free Appropriate Public Education (FAPE)**

An entitlement of all youth in the U.S., as specified in the Individuals with Disabilities Education Act and in Section 504 of the Vocational Rehabilitation Act. These regulations require a school district to provide special education and related services, at no cost to a child or his or her parents, so any child needing these services may take advantage of his or her public education.

### **Functional Behavioral Assessment (FBA)**

A process that provides a framework for developing effective programs for students who present serious problem behavior. It examines the events that reliably predict and maintain problem behavior while using a strength-based approach that considers the "whole child" and the context in which the behavior occurs. It addresses problem behavior by developing behavior support plans (BSP) that move away from being reactive and punitive in nature, to plans that are proactive with research-validated practices. The approach is geared at utilizing a student's strengths to provide a basis for plan development, instructional programming, and behavior management that are geared to each individual's needs, preferences, and long-term goals.

### **Grievance**

Any oral or written communication, made by or on the behalf of a consumer, provider and others that expresses dissatisfaction with any aspect of CAMHD's operations, activities, behavior or providers and its sub-contractors.

### **Group Therapy**

Regularly scheduled, individual, face-to-face therapeutic services for groups of two or more youth designed to promote healthy, independent functioning for the purpose of treating emotional and behavioral disturbances that prevent the youth from functioning adequately.

### **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**

An Act of Congress that amended the Internal Revenue Code of 1986 in order to improve the portability and continuity of health insurance coverage. This act includes requirements for ensuring the confidentiality of protected health information and standards for the electronic transmission of certain health information.

**IDEA** - See, Individuals with Disabilities Education Act

**IEP** - See, Individualized Education Program

### **Independent Psychiatrist**

A psychiatrist who is not an employee or under contract with a contractor or CAMHD and who is ABPN board certified in Child and Adolescent Psychiatry.

### **Individual Therapy**

Regularly scheduled, individual, face-to-face therapeutic services designed to promote healthy, independent functioning for the purpose of treating emotional and behavioral disturbances that prevent the youth from functioning adequately.

### **Individuals with Disabilities Education Act (IDEA)**

An Act of Congress to insure that all children with disabilities have available to them a free appropriate public education that emphasizes special education and related services designed to meet their unique needs and prepare them for employment and independent living.

### **Individualized Education Program (IEP)**

A written statement for each child with a disability that is developed, reviewed and revised in accordance with Section 614 (d) (Individualized Education Programs) of the Individuals with Disabilities Education Act, as amended in 1997. The statement includes a description of the student's present levels of educational performance, annual goals including short-term objectives, special education and related services, dates for beginning and duration of services, and measure for how progress on implementation of the services will be evaluated.

### **Integrated Special Education Database (ISPED)**

This is the DOE's Official Electronic confidential Record System for students who have been referred for an initial evaluation or reevaluation and found eligible or ineligible for Section 504 or Individuals with Disabilities Education Act (IDEA) services. It is the vehicle through which information is used to provide timely services to students.

**Joint Commission on Accreditation of Healthcare Organizations (JCAHO)** – See, Accreditation.

**K-SADS** - See, Schedule for Affective Disorders and Schizophrenia for School Aged Children

### **Least Restrictive Environment (LRE)**

The most natural therapeutic environment that is appropriate to individual needs.

### **License**

For facilities, this is a document issued by the Hawaii State Department of Health indicating that a facility, program, and staff meet the standards set by the State for a given level of mental health care. For individual professionals, this is a document issued by the Hawaii State Department of Commerce and Consumer Affairs (DCCA) Professional and Vocational Licensing Division.

### **Licensed Professional**

Refers only to individuals who are licensed by the State of Hawaii to provide mental health services in his/her respective area of expertise.

### **Locked Unit**

A hospital or residential psychiatric unit that is physically secure, requiring staff assistance with unlocking and relocking doors in ingress and egress.

**LRE - See, Least Restrictive Environment**

### **Mechanical Restraint**

Any device attached or adjacent to a youth's body (e.g. four-point bed restraint) that restricts a youth's movement.

### **Medicaid or Quest Eligibility**

The process by which an individual is eligible for Medicaid Fee-for-Service or QUEST.

### **Medication Evaluation**

A physician's assessment of a youth's presenting symptomatology for the purpose of possible prescription and administration of medication.

### **Medication Monitoring**

The ongoing assessment of a youth's response to medication, symptom management, side effects and adjustment in medication dosage.

### **MED-QUEST Division (MQD)**

The State office that has the responsibility for administering the medical assistance programs for the Department of Human Services.

### **Mental Health Care Coordinator (MHCC)**

CAMHD staff at each CAMHD branch who is responsible for the coordination of home visits, school visits, community contacts, convening the initial CSP meeting, referral for services, family engagement, maintaining contact with the youth, ensuring timely delivery of services and continuous monitoring of youth progress.

### **Mental Health Treatment Plan (MHTP)**

A comprehensive plan, developed by contractors, to address the mental health needs of a youth and his/her family that includes specific goals, measurable objectives, target dates to reach objectives, appropriate interventions to achieve these objectives, a crisis plan identifying specific actions to take in case of a mental health emergency, and a discharge plan to prepare for a smooth transition to eventual termination of services.

**MHCC** - See, Mental Health Care Coordinator

**MHTP** - See, Mental Health Treatment Plan

### **Milieu Therapy**

The type of treatment in which the patient's social environment is manipulated for his/her benefit.

### **Modification Plan (MP)**

A written statement describing the specific regular or adapted regular educational services and related services to be provided to a student who does not require special education, but whose disability requires modifications to prevent exclusion from full participation in his/her education program as per Section 504 of the Vocational Rehabilitation Act of 1973.

### **Monthly Credentialing Report**

An alphabetical listing, submitted by Contractors, sorted by last name of all staff and sub-contractors, position title, credentialed start and end dates and termination dates with Med-QUEST reason codes for terminations that occur within the reporting period.

### **Monthly Treatment and Progress Summary (MTPS)**

Monthly reports submitted electronically by CAMHD contractors describing the services provided and progress of youth and family receiving services that includes: youth served, service format, service setting, service dates, treatment targets, intervention strategies, medications projected end date, and ratings indicating the progress achieved between baseline assessment and the recovery goal for measures of each treatment target. Additional outcome measures may also be reported.

**MP** - See, Modification Plan (MP)

**MQD** - See, MED-QUEST Division

**MTPS** - See, Monthly Treatment and Progress Summary

### **No Child Left Behind (NCLB)**

The NCLB Act of 2001 is a Federal law that imposes certain requirements of state education agencies. As applied to Hawaii, by the end of school year 2013-2014, the DOE must ensure that all students meet or exceed a “proficient” level of academic achievement on required State assessments (i.e. Reading, mathematics and science) and other academic measures (i.e. graduation rate for high schools and retention rate for elementary and middle schools). All schools must also make adequate yearly progress toward achieving the 100% goal. The Act is also concerned about certain subgroups of students (e.g. economically disadvantaged, from major racial and ethnic groups, those with disabilities and those with limited English proficiency). These subgroups must make adequate yearly progress on all required assessments.

### **Non-Aversive Interventions**

Interactions with a youth that are meant to avert a crisis (such as taking a walk with a youth who is agitated), and that do not involve physical discomfort, removal of privileges, or punishment of any kind.

### **Out-of-Home Placements**

These service placements include: Therapeutic Foster Homes, Multidimensional Treatment Foster Care, Therapeutic Group Homes, Independent Living Programs, CBR I, II and III, Hospital Based Residential, Community-based Clinical Detoxification, Respite Foster Home, Community Mental Health Shelter and Respite Home.

### **Out-Patient Placements**

These service placements include: Comprehensive Mental Health Assessment; Focused Mental Health Assessment; Summary Annual Assessment; Individual Therapy, Group Therapy, Family Therapy; Peer Support, Functional Family Therapy; Intensive In-Home Intervention; Multisystemic Therapy, Psychiatric Evaluation; Medication Management; Parent Skills Training; Intensive Outpatient for Independent Living Skills; Intensive Outpatient for Co-Occurring Substance Abuse; Partial Hospitalization and Psychosexual Assessment.

**PECAFAS** - See, Preschool and Early Childhood Functional Assessment Scale.

### **Peer Review**

Educational and administrative meetings that involve professional colleagues reviewing clinical work and providing constructive feedback or planning of educational programs. Active participation in structured review activities such as an evidence-based services committee is considered peer review for purposes of the IPSPG as the process involves reading, coding, and reviewing published research. Informal peer review includes collegial activities such as journal clubs, peer supervision, continuous case conferences and planning meetings for continuing education conferences. Formal peer review may lead to disciplinary and corrective actions such as reduction in privileges, special conditions, or added supervision.

### **Preschool and Early Childhood Functional Assessment Scale (PECFAS)**

The PECFAS is a rating scale that assesses a child's degree of impairment in day-to-day functioning due to emotional, psychological or psychiatric problems. It is rated on children aged 3-6 years and is used to track clinical outcomes, to assign youth to appropriate levels of care and as part of the criteria used to determine a child's eligibility for CAMHD's SEBD program.

### **Primary Source**

An organization or entity with legal responsibility for originating a document and ensuring the accuracy of the information it conveys.

### **(PRN) Orders**

PRN comes from the Latin phrase pro re nata and means “as needed” as ordered by a physician or licensed health care provider with prescriptive authority.

### **Provider**

Organization or individual who is has a written contract or memorandum of agreement with CAMHD or Doe to provide behavioral/mental health services. May also be referred to as Provider or Contracted Provider

### **Psychological Testing**

Psychodiagnostic evaluation of personality, psychopathology and cognitive functioning based on the referral question that includes testing, score, interpretation and written report.

### **Psychotherapy**

An intervention strategy that helps people with their emotional/social/mental processes. An individual providing psychotherapy meets the Qualified Mental Health Professional requirements as stated in Section I General Standards.

### **Quality Assurance and Improvement Program (QAIP)**

A methodical and objective approach to monitoring and evaluating the appropriateness and quality of individual care in order to improve an organization’s performance. A written and comprehensive plan that establishes and coordinates review mechanisms.

### **Quality Assurance Reform Initiative (QARI)**

The Quality Improvement System for Managed Care (QISMC) standards and guidelines pertaining to quality measurement and improvement and the delivery of health care and enrollee services. These standards and guidelines were developed by the Health Care Financing Administration (HCFA), which is now known as Centers for Medicare and Medicaid Services.

### **QUEST**

A Hawaii State government program that provides medical assistance coverage through managed care plans for income-eligible Hawaii residents.

### **Re-Authorization**

A formal procedure that extends the authorization of service units for a youth beyond the initial authorization for services and is based on criteria for continued treatment within specified levels of services.

### **Referral**

The formal process of informing Contractors of youth who need their mental health services.

### **Restraint**

The restriction of freedom of movement through personal, drug or mechanical means in order to protect the individual from injury to self or to others. Also see CAMHD Restraint and Seclusion Procedure 80.602, Sentinel Events Policy and Procedure 80.805, (Appendix B) and Section I General Standards, Q. Risk Management 3. Restraints and Seclusion for event code definitions and reporting requirements.

### **Risk Assessment**

An assessment of a youth's potential to be harmed by others or to cause significant harm to self or others. This includes suicide, homicide, and unintentional harm from misinterpretations of reality, inability to adequately care for oneself or temper impulses with judgment, intoxication, or inability to perceive threats to safety. It may include a hostile environment where a youth would be unable to protect himself or herself. A history of dangerous behaviors and/or abuse and/or neglect can be considered in a risk assessment.

**SBBH** - See, School-Based Behavioral Health

### **Schedule for Affective Disorders and Schizophrenia for School Aged Children (K-SADS)**

The K-SADS is a semi-structured diagnostic interview designed to assess episodes of psychopathology in children and adolescents (ages 6-18) according to DSM III-R and DSM IV criteria. There is a lifetime version and a present episode version. The K-SADS is administered by interviewing the parent(s), the child, and finally achieving summary ratings, which include all sources of information.

### **School-Based Behavioral Health (SBBH)**

Behavioral and mental health services provided to students in their respective school environments. Also, a section of the Hawaii Department of Education Comprehensive Student Support System that administers these services and whose goal is to support the healthy social and behavioral development of all students by providing clearly communicated social, behavioral and academic expectations and supported learning environments.

### **SBBH Services FY \_\_ Final Report**

This is a summary report for the contract period that contracted provider agencies submit to the DOE per procurement requirement. It is an agency self-assessment report that provides information regarding the overview of the delivery of services, unique qualities of the program, areas needing improvement, barriers to providing services, quality management, staff summary, staff training, evaluation of staff and subcontractors and future plan of action.

**SEBD** - See, Support for Emotional and Behavioral Development

### **Seclusion**

Involuntary confinement of a person in a room or an area physically prevented from leaving, and under constant staff observation and supervision. Also see CAMHD Restraint and Seclusion Procedure 80.602, Sentinel Events Policy and Procedure 80.805, (Appendix B) and Section I General Standards, Q. Risk Management 3. Restraints and Seclusion for event code definitions and reporting requirements.

### **Section 504 – (Subpart D of the Rehabilitation Act of 1973)**

A section of the federal Vocational Rehabilitation Act of 1973 that protects qualified individuals from discrimination based on their disability. Section 504 defines the rights of individuals with disabilities to participate in, and have access to, all program benefits and services of employers and organizations who receive financial assistance from any federal department or agency, including the U.S. Department of Health and Human Services (DHHS), hospitals, nursing homes, mental health centers and human service programs.

### **Sentinel Event**

An occurrence involving serious physical or psychological harm to anyone or the risk thereof. (See CAMHD Sentinel Events Policy and Procedure 80.805 (Appendix B) for event code definitions and reporting requirements). A Sentinel Event includes 1) any inappropriate sexual contact between youth, or credible allegation thereof; 2) any inappropriate, intentional physical contact between youth that could reasonably be expected to result in bodily harm, or credible allegation thereof; 3) any physical or sexual mistreatment of a youth by staff, or credible allegation thereof; 4) any accidental injury to the youth or medical condition requiring transfer to a medical facility for emergency treatment or admission; 5) medication errors and drug reactions; 6) any fire, spill of hazardous materials, or other environmental emergency requiring the removal of youth from a facility; or 7) any incident of elopement by a youth.

### **Social History**

A report on a youth that includes information about the school, home, peer, and community domains of the youth's life over time. The report is a result of interviews with the youth, family, significant others, and a thorough review of available formal documents.

**SPO** - See, State Procurement Office

**SSP** - See, Student Service Plan

**Standing Orders** - See PRN orders.

### **State Facility License**

A document issued by the Hawaii State Department of Health indicating that a facility, program, and staff meet the standards set by the State for a given level of mental health care.

### **State Plan Amendment**

Refers to amendments to the State Medicaid plan, which is the contract between the State and Federal government whereby the State agrees to administer the Medicaid program in accordance with Federal law and policy. Anytime a State wishes to make changes to services or participation requirements in its State Medicaid plan, those revisions must be approved by the Centers for Medicare and Medicaid Services (CMS)

### **State Procurement Office (SPO)**

The Hawaii government unit that serves as the central office for obtaining certain goods and services for all governmental bodies of the State and its counties.



### **State Professional and Vocational Licensing**

The Division of the State of Hawaii Department of Commerce and Consumer Affairs that licenses professionals. A search of this division is conducted for complaints history and to determine whether an applicant's license is current, valid and in good standing.

### **Strength-Based Service**

Any mental health service for a youth that is based on the strengths of the youth as well as the problems.

### **Student Service Plan (SSP)**

This is a plan specific to the individual provider (DOE employee and contracted) delineating the evidence-based strategies, projected intervention timelines, exit/transition plan, progress monitoring and outcome measures which will be used to address the student's IEP/MP goals and objectives that the school has selected for the provider to address.

### **Support for Emotional and Behavioral Development (SEBD)**

SEBD is CAMHD's program for children and youth between the ages of 3 through 20 years who have Hawaii QUEST or Medicaid Fee-For-Service insurance and who have significant problems with emotions, behaviors or psychological functioning as evidenced by a CAFAS/PECFAS score of 80 or above. Children and youth meeting the SEBD criteria are eligible to receive all of the mental health services in CAMHD's full service array.

### **System of Care**

A comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and adolescents with severe emotional disturbances and their families.

### **TB Test**

Admission or residence at a facility requires a certificate of TB examination issued within 12 months indicating that the youth is free from communicable tuberculosis. The examination involves a tuberculin test and, if the test shows a positive reaction, a chest x-ray is needed. Chest x-rays consistent with tuberculosis require further follow up to exclude communicable tuberculosis before a certificate can be issued. Without a certificate, a current tuberculin test is required immediately prior to or upon admission and annually thereafter, unless the youth has a documented history of a positive tuberculin skin test, which calls for annual chest x-rays. If placement is urgent, a chest x-ray completed immediately prior to admission will be acceptable with completion of a tuberculin test within a week of admission unless the youth has a documented history of a positive tuberculin skin test.

### **Telephone Device for the Deaf (TDD or TTY)**

A technology device that allows those with hearing problems to send and receive text-based messages through phone lines.

### **Text Telephone Display (TTD)**

Assistive technology device used with telephones to allow text-based messages to be delivered through phone lines.

### **Therapeutic Group Homes (TGH)**

A type of residential placement for youth that provides 24-hour care and integrated service planning addressing the behavioral, emotional or family problems that prevents the youth from taking part in family and/or community life. These homes are designed for students whose needs can best be met in a structured program of small group living in a community-based setting where they can remain involved in community-based educational, recreational and occupational activities.

### **Therapeutic Pass**

Therapeutic passes are used to assist a youth with maintaining/improving family relationships, generalizing skills to the home/community and transition to home/community living. Therapeutic passes are provided in accordance with the treatment plan and approved by the MHCC in advance except for unplanned family emergencies. Therapeutic passes are paid at 100% of the contracted rate up to the number of days specified in the service-specific standard. Therapeutic passes beyond the threshold are reimbursed at 50% of the contracted rate.

### **Title IV-E Training Activity and Cost Reports**

Quarterly provider trainer and trainee activity and cost reports that are reviewed by the CAMHD Resources Development Section for eligibility under Title IV-E federal funding.

### **Transition Plan**

That section of a treatment plan (e.g. IEP, BSP, MHTP, CSP) for a youth that specifies the supports and services to be provided to prepare that person for a change from one type of service to another or from one type of service to discharge or from status as a youth to an adult. The 1997 amendments to the Individuals with Disabilities Education Act (IDEA) emphasized that students with disabilities are to be prepared for employment and independent living as they transition to adulthood and that specific attention is to be paid to the secondary education they receive so they may be prepared for this change. Section 300.29 of the IDEA regulations defines transition service as a coordinated set of activities for a student with a disability that 1) is designed within an outcome-oriented process, that promotes movement from school to post-school activities, including post secondary education, vocational training, integrated employment (including supported employment), continuing and adult education, adult services, independent living, or community participation; 2) is based on the individual student's needs, taking into account the student's preferences and interests; and 3) includes instruction, related services, community experiences, the development of employment and other post-school adult living objectives, and if appropriate, acquisition of daily living skills and functional vocational evaluation. (See also discharge plan, exit plan).

### **Treatment**

The broad range of emergency, out-patient, intermediate, domiciliary, and in-patient services and care, including diagnostic evaluation, medical psychiatric, psychological, and social services care, vocational rehabilitation, career counseling, and other special services that may be extended to individuals with mental health disorders.

### **Treatment Plan**

See "Mental Health Treatment Plan" (MHTP) "Behavioral Support Plan" (BSP), Student Service Plan (SSP) or "Coordinated Service Plan" (CSP).

### **Treatment Team**

A multi-disciplinary team consisting of the youth, family, service providers, MHCC, school personnel and other individuals involved in the welfare of the youth.

### **Treatment Team Meeting**

A meeting of members of a youth's treatment team for the purpose of developing, coordinating, reviewing, and/or updating that youth's treatment plan.

**TRF** - See, ASEBA Teacher Report Form (TRF)

**TTD** - See, Text Telephone Display

### **Unplanned Family Emergency**

Unplanned family emergencies most commonly include, but are not limited to, situations such as death, illness, or accident involving a family member.

### **Waiver**

An exemption for a period of one year or less, from a specific rule, standard, or accreditation requirement which may be permitted a facility for a specified period of time, at the discretion of the CAMHD Chief or designee.

### **Waitlist**

Youth a program has accepted for services but who cannot be admitted yet due to lack of available beds. Waitlisted youth must be reported to CAMHD weekly on the Weekly Census Report on Youth Status.

### **Weekly Census Report on Youth Status, CAMHD**

A form that out-of-home Contractors submit to CAMHD by Tuesday of each week includes the date of admission, youth's name and gender, the referring FGC, projected discharge date, actual discharge date, discharge placement, and wait-listed youth.

### **Youth**

Any person who is no younger than 3 years of age and no older than 21 years of age.

### **YSR**

See, ASEBA Youth Self-Report (YSR)

***SECTION VI:***  
**APPENDICES**

***SECTION VI – APPENDIX A:***  
**DOE DOCUMENTS**

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

### Appendix A DOE Documents (As referenced in General Standards and SBBH Standards)

Document	Name of Document
1.	Comprehensive Student Support System (CSSS)
2.	Request for Assistance Flowchart
3.	CSSS Array of Student Support
4.	Array of School Counseling/Behavioral Supports
5.	Standards of Practice <ul style="list-style-type: none"><li>a. Standards of Practice</li><li>b. Functional Behavioral Assessment</li><li>c. Emotional Behavioral Assessment</li><li>d. Counseling</li><li>e. Parent Education, Counseling/Training</li><li>f. Lead and Direct a Skills Trainer</li><li>g. Individualized Instructional Supports</li><li>h. Medication Management and Procurement Procedures</li><li>i. Psychiatric Diagnostic and Medication Evaluation</li><li>j. Intensive Learning Center</li><li>k. Special School</li></ul>
6.	FBA (Functional Behavior Assessment) and BSP (Behavior Support Plan) Guide
7.	Functional Behavior Assessment (sample)
8.	Behavior Support Plan Brainstorming (sample)
9.	Behavior Support Plan Implementation (sample)
10.	Functional Behavior Assessment form
11.	Behavior Support Plan Brainstorming form
12.	Behavior Support Planning Worksheet
13.	Behavior Support Plan Implementation form
14.	DOE Guidelines for Water Related Activities
15.	Emotional Behavioral Assessment Psychiatric Diagnostic Evaluation (format)
16.	Emotional Behavioral Assessment: Annual Update/Psychiatric Medication Evaluation (format)
17.	Psychiatric Medication Management Progress Note form
18.	Referral Checklist for Emotional Behavioral Assessments, Psychiatric Diagnostic and Medication Evaluations
19.	School Based Behavioral Health Quarterly Progress Report
20.	Sentinel Event/Incident Notification for DOE Contracted Providers
21.	Service Verification form
22.	Student Service Plan
23.	Request for Evaluation Form 101

Note: These documents are current as of November 2005. Please refer to the CSSS website for the most current versions <http://www.csss.k12.hi.us> under resources.

**DEPARTMENT OF EDUCATION  
COMPREHENSIVE STUDENT SUPPORT SYSTEM**

The Department of Education's Comprehensive Student Support System (CSSS) provides an array of student support services that identifies the current resources available at the school, complex, and state level in the five levels of student support. This array provides school personnel, parents, students, and the community with an awareness of the different services and programs available to support student learning.

**Function**

The array of student support services ensures that the supports provided and the delivery process corresponds to the severity, complexity, and frequency of each student's needs. Each level increases in intensity or specialization of service. CSSS includes five levels of support in its Array of Student Support Services.

**Level 1: Basic Support for All Students**

Students have diverse needs that are addressed in the inclusive classroom. At Level 1, the key to successful student support is the classroom teacher who involves the student and family in working together. While the response does not require a formal meeting or written plan, it does require commitment to and understanding of the differentiated classroom practices. Teachers, along with other school personnel, routinely provide support and guidance to students at school and assist families in addressing the students' needs at home.

**Level 2: Informal Additional Support Through Collaboration**

Level 2 assistance is additional support beyond what the classroom teacher primarily provides. There is more targeted collaboration with various other school personnel, e.g., the counselor, SSC, administrator, department or grade level teachers. These support activities are carried out in an informal, supportive manner.

**Level 3: Individualized School and Community Based Programs**

Level 3 services encompass even further assistance designed for specific groups or needs. Level 3 supports are generally provided after the Student Support Team (SST) meeting. The SST meeting includes parents or family members, teachers, and/or other school or community personnel, who develop an action plan that addresses the student's need. Staff and families continue to be involved in monitoring the student's progress.

**Level 4: Specialized Services from DOE and/or Other Agencies**

When a student requires specialized assessment or assistance, a Student Support Team is convened by the SSC to collaboratively develop a plan that meets the needs of the student. The SST develops an action plan that may include a referral for Section 504, special education, related services, community agency support, mental health services, as well as Level 1, 2, or 3 services. At this level, there are IDEA, Section 504, equity, and other legal requirements that must be complied with.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### Level 5: Intensive and Multiple Agency Services

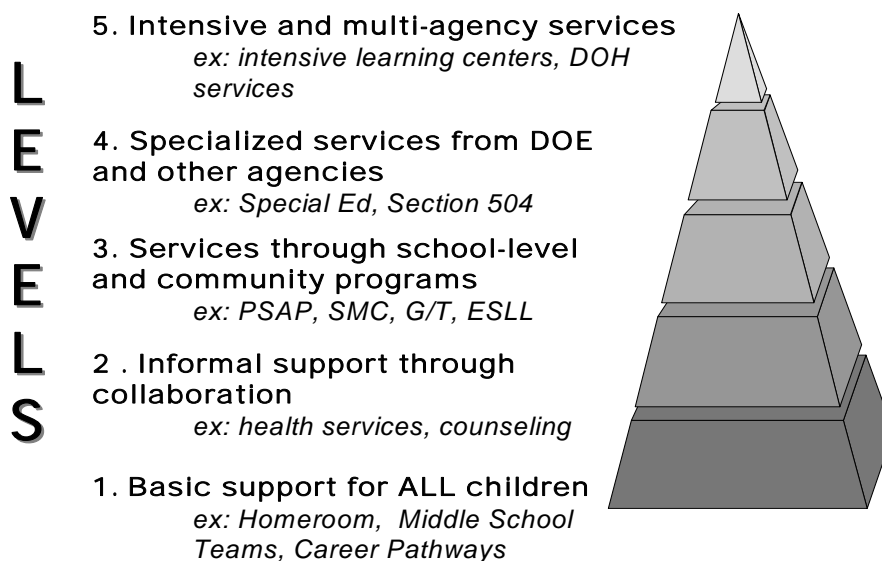
When the needs of the student and family require intensive multi-agency supports, the SST develops an action plan that integrates the resources and services of the DOE and other agencies. Student placement may be at off-campus therapeutic and/or educational programs. Schools continue to dialogue with the families and agencies to ensure a smooth transition.

### CSSS LEVELS OF NEED FOR SCHOOL BASED SERVICES AND SUPPORTS

CHARACTERISTICS OF THE CHILD				
Informal Supports		Programs/Services		Coordinated Services
1	2	3	4	5
Child functions well, has good coping skills. May have dependable supports at home. May need self-help resources. Can self-initiate needed services without outside assistance.	Child usually functions well, has fair coping skills. May have dependable supports at home. May need one-time support or occasional assistance for a low level need.	Child functions fair in most situations, has some coping skills. Home supports may be limited. May learn more slowly or have a chronic health problem. May need special supports in one area.	Child may have substantial functional limitations and inconsistent coping skills. May require specialized services one area provided via a special plan.	Child may have extensive functional limitations. May require residential services or alternative educational placement. Needs intensive specialized services in multiple settings. Needs coordinated services and major transition supports between settings.

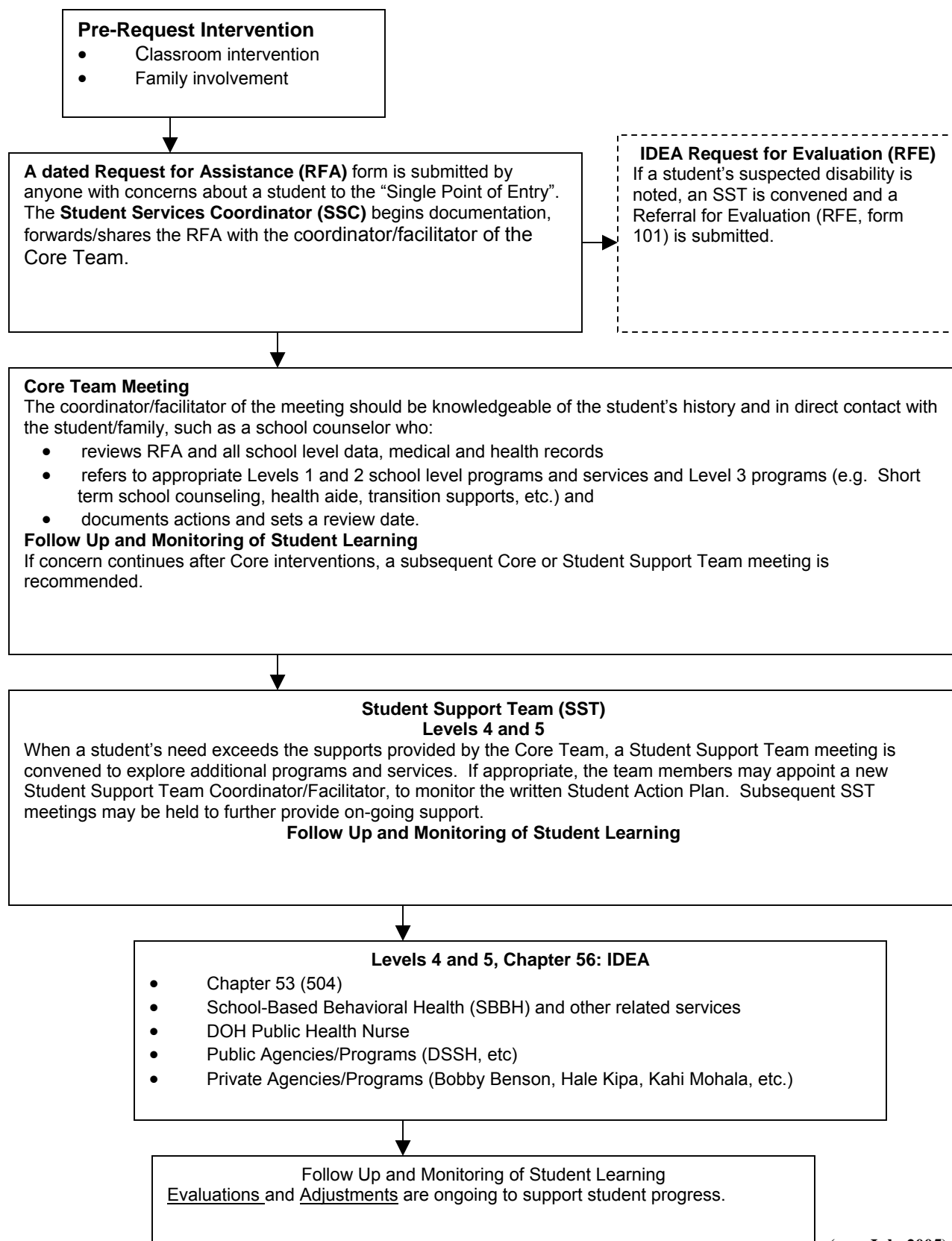


## CSSS Continuum of Support Services



# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## REQUEST FOR ASSISTANCE FLOWCHART



(rev. July 2005)

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CSSS Array of Student Support

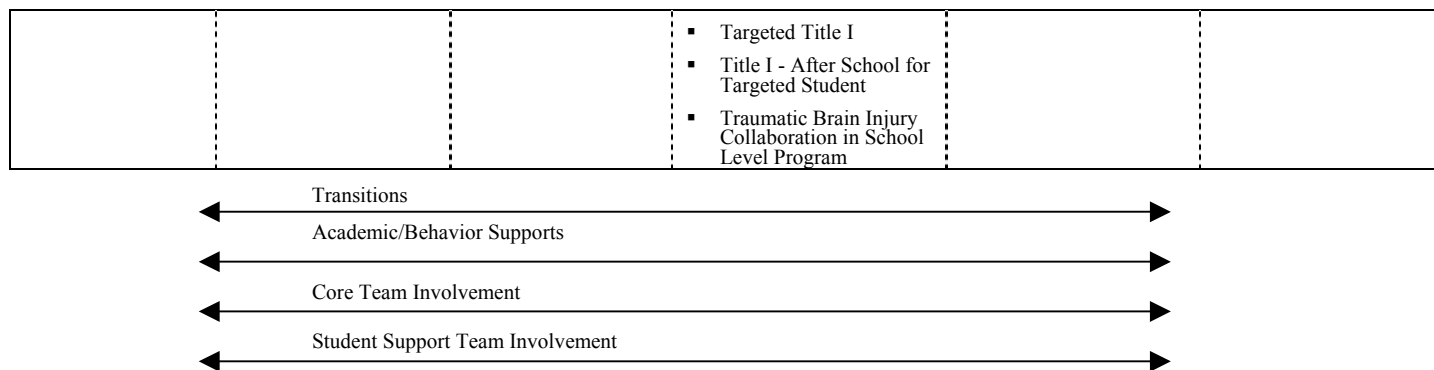
Levels of Support	Level 1: Basic support for all students	Level 2: Informal additional support through collaboration	Level 3: Individualized school and community sponsored programs	Level 4: Specialized services from DOE and/or agencies	Level 5: Intensive, higher level and multiple agency services
<b>Basic Components</b>	<ul style="list-style-type: none"> <li>Relations between               <ul style="list-style-type: none"> <li>Student and peers</li> <li>Student and teacher</li> <li>Teacher and teachers</li> <li>Teacher and family</li> <li>Classroom supports</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Teachers</li> <li>School-level support personnel</li> <li>Students</li> <li>Families</li> <li>Agencies</li> </ul>	<ul style="list-style-type: none"> <li>Programs beyond regular classroom considered at Student Support Team Meetings through Request for Assistance (RFA) process</li> <li>Request, decisions, plans are documented at Core/SST meetings</li> </ul>	<ul style="list-style-type: none"> <li>Section 504, IDEA issues addressed through Request for Evaluation</li> <li>Programs beyond Level 3 considered at the Student Support Team meetings through the RFA process</li> <li>Care Coordinator identified</li> <li>Service Plan is developed</li> </ul>	<ul style="list-style-type: none"> <li>Coordinated Service Plans</li> <li>Multi-agency Student Support Teams</li> <li>Possible off-campus placement</li> </ul>
<b>Examples</b>	<ul style="list-style-type: none"> <li>Advisor-Advisee</li> <li>Career Pathways</li> <li>Coordinated School Health</li> <li>Counseling - Comprehensive school programs - guidance, social skills, character ed</li> <li>Family Support/Health</li> <li>Homeroom</li> <li>Middle-School Team</li> <li>Occupational Therapy School-wide inservice</li> <li>Parent Involvers</li> <li>Parent/Teacher conference</li> <li>PSAP* Outreach, welcome, transition</li> <li>Physical Therapy School-wide inservice</li> <li>SBBH School-wide inservice</li> <li>School-wide Title</li> <li>Speech/Lang Path School-wide inservice</li> <li>Traumatic Brain Injury Specialist School-wide inservice</li> </ul>	<ul style="list-style-type: none"> <li>After School Supplementary Program</li> <li>Counseling - School Walk-in</li> <li>Health Aide Services</li> <li>Occupational Therapy Consult</li> <li>Peer Mediation</li> <li>Physical Therapy Consult</li> <li>SBBH Consult</li> <li>Service for Homeless</li> <li>Speech/Lang Path Consult</li> <li>Study Hall</li> <li>Traumatic Brain Injury Specialist Consult</li> </ul>	<ul style="list-style-type: none"> <li>Advanced Placement</li> <li>Community Sponsored Program</li> <li>Counseling – Group</li> <li>Counseling and Guidance – CSAP</li> <li>Counseling – Individualized</li> <li>ESLL**</li> <li>Gifted and Talented</li> <li>Home-Hospital Instruction</li> <li>Honors</li> <li>Medical Specialist</li> <li>Occupational Therapy Collaboration in School Level Program</li> <li>Pregnant/Parenting Teens</li> <li>PSAP*</li> <li>Public Health Nursing</li> <li>Physical Therapy Collaboration in School Level Program</li> <li>SBBH Collaboration in School Level Program</li> <li>School - Family Assistance</li> <li>School Attendance Program (SAP)</li> <li>School Enrichment Program</li> <li>SMP***</li> <li>Specific School Sponsored Program</li> <li>Speech/Lang Path Collaboration in School Level Program</li> <li>Supplementary Math</li> <li>Supplementary Reading</li> </ul>	<ul style="list-style-type: none"> <li>ALC****</li> <li>Child Protective Service</li> <li>Community Agency - Specialized Service</li> <li>Counseling - Child and Family Crisis</li> <li>Early Admit to College</li> <li>Family Court</li> <li>IDEA</li> <li>Parent Education and Training</li> <li>Related Services</li> <li>Section 504</li> <li>Supplementary Aids and Supports</li> </ul>	<ul style="list-style-type: none"> <li>Community Based Intensive Program</li> <li>DOE-Connected Intensive Program</li> <li>IDEA</li> <li>Intensive Services coordinated with or within other intensive programs</li> <li>Parent Education and Training</li> <li>Related Services</li> <li>Residential Treatment Programs</li> <li>Substance Abuse Treatment Program</li> <li>Supplementary Aids and Supports</li> </ul>

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

### CSSS Array of Student Support



- \* Primary School Adjustment Project
- \*\* English for Second Language Learners
- \*\*\* Special Motivation Program
- \*\*\*\* Alternative Learning Center

(revised 10/11/04)

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## Array of School Counseling/Behavioral Supports

	Level 1	Level 2	Level 3	Level 4	Level 5
<b>Levels of Support</b>	Basic support for all students	Informal additional support through collaboration	Individualized school and community sponsored programs	Specialized services from DOE and/or contracted agencies	Intensive and multiple agency services
<b>Function</b>	Personalization, Prevention	Personalization Risk Reduction	Early Intervention	Intervention	Intervention
<b>Target Population</b>	All students	Students exhibiting at-risk behaviors	Students with mild or situational difficulties; e.g., divorce, death in family	Students with moderate behavioral health problems; e.g., hyperactivity	Students with more severe and/or complex behavioral health problems
<b>Identification Process</b>	Attention to the developmental needs of all students	Recognition of at-risk influences on individual or groups of students, informal functional behavior assessment process	Review by school personnel of child's current functioning via RFA/FBA (Functional Behavior Assessment) process	FBA process; 504 or SpEd eligibility; RFE/IEP/MP team	FBA and Emotional/Behavioral Assessment with diagnosis of disorder; 504 or SpEd eligibility
<b>Focus</b>	Personal Plan: Building relationships, strengthening resiliency Career Guidance	Personal Plan: Building relationships, strengthening resiliency	Improving students' functioning	Developing effective coping skills/ strategies to address barriers	Reducing intensity and severity of problematic behaviors; intensive skill building
<b>Possible Services and Supports</b>	Comprehensive school counseling program  Support teachers efforts in providing guidance, social skills, character education, on campus and in the classroom	Comprehensive school counseling program : ie. Walk in counseling, Behavior Support Plan (BSP), transition planning, guidance/ curriculum programming, teacher/parent consultation, plus Level 1 supports	BSP, Short -term counseling sessions, PSAP, teacher/parent consultation, plus Level 1 and 2 supports	BSP, Individualized modifications and interventions, ALC, teacher/parent consultation, parent education/counseling, plus Levels 1, 2, and 3 supports	BSP, Specialized programming; e.g., Therapeutic Classrooms, Enhanced Learning Centers, CBI, residential placement, teacher/parent consultation, parent education/counseling
<b>Staff Involved</b>	<div> <div>←</div> <div>ALL</div> <div>SCHOOL</div> <div>STAFF</div> <div>→</div> </div>				School or Community-based Intensive Programs, DOH services, with school staff assistance during transitions
<b>*Peer Review / QA</b>	<div> <div>←</div> <div>ASSESS EFFECTIVENESS OF SERVICES</div> <div>→</div> </div>				

Transition Supports

Positive Behavior Supports

\*Schools may call this function by different names but the purpose is to assess effectiveness of service delivery, etc.

revised 7/02/04

## ***Standards of Practice***

Statewide ***Standards of Practice*** have been developed to guide teams in the process of using appropriate evidence and consultation to make educational decisions for students. The ***Standards of Practice*** are written to facilitate the delivery of quality services, and at the same time, to assure accountability and responsibility on the part of all professionals involved with the delivery of educational services.

The ***Standards of Practice***:

- Improve quality services to students
- Promote state-wide consistency
- Promote Best Practices
- Conform to the Interagency Performance Standards and Practice Guidelines

Developed within the framework of the Department of Education's Comprehensive Student Support System (CSSS), the ***Standards of Practice*** focus on CSSS levels 4 and 5 services. They are intended to be utilized by the school to collect and analyze data and to discuss if more information is needed for the IEP/MP teams to determine the need for a specific service. They are not to be used to pre-determine services in the IEP or to exclude CSSS levels 1-3 supports.

These ***Standards of Practice*** are to be used statewide for both employee delivered services as well as contracted services. As more ***Standards of Practice*** are developed for other services, they will be disseminated for statewide implementation.

***STANDARDS OF PRACTICE for  
Considering Functional Behavioral Assessment***

**A Functional Behavioral Assessment (FBA) is a process that:**

- **Provides a framework for developing effective supports for students;**
- **Examines events that reliably predict and maintain problem behaviors;**
- **Uses strengths-based approach that considers the “whole student” and in the context the behavior occurs;**
- **Utilizes student’s strengths to provide a basis for plan development, instructional programming, and behavior management;**
- **Involves a team of staff and family who know the student well to identify the concerns, gather data, develop a hypothesis and behavior support plan (BSP) and implement the BSP.**

<b>Data gathering and Considerations</b>	<b>YES</b>	<b>NO</b>
<p>1. Has the teacher initiated a systematic plan to use a variety of instructional strategies to engage the student in his/her learning?</p> <p>If NO, please initiate.</p>		
<p>2. When behavior difficulties were noted, has the teacher tried different interventions in the classroom? Describe them:</p> <p>If NO, please implement.</p>		
<p>3. a. Has the teacher consulted with other teachers in school, educational resources (i.e., reading specialist, district resource teacher, school reform specialist,) the school counselor, or behavior specialist for assistance?</p> <p>What was attempted as a result of the consult?</p> <p>b. For students who have transferred between schools/agencies/facilities, have members of both the present and former schools/agencies/facilities collaborated to ensure that all pertinent information about the student has been exchanged?</p> <p>If NO, please consult and collaborate.</p>		

***STANDARDS OF PRACTICE for  
Considering Functional Behavioral Assessment***

<p>4. Has the Complex School Social Worker or DOE counseling provider (school counselor, behavior specialist, school/clinical psychologist) interviewed the parent(s) and completed a Structured Developmental History (SDH) to obtain other important information about the student's learning difficulties, i.e., family and living situation, cultural factors, developmental and medical history, etc?</p> <p>If YES, are there any significant factors to consider and incorporate into the IEP and/or BSP? (i.e., medical, developmental, vision difficulties)</p> <p>If NO, please conduct the SDH interview and utilize data appropriately.</p>	<b>YES</b>	<b>NO</b>
<p>5. If the problem behavior escalated or interventions were not effective, did the school team conduct a Functional Behavioral Assessment (FBA)?</p> <p>If NO, develop a Functional Behavioral Assessment (FBA) and a Behavior Support Plan (BSP). Refer to the FBA/BSP Guide and samples.</p>		
<p>6. Was the BSP implemented on a consistent basis by all relevant parties for at least 6 weeks and revised as needed, with documentation and progress monitoring data?</p> <p>If NO, please implement consistently or revise, with documentation.</p>		
<p>7. If behavior did not improve or the behavior escalated, was the complex school psychologist/clinical psychologist and/or behavioral specialist consulted to assist the school with behavioral assessment/interventions?</p> <p>If YES, what was recommended and implemented?</p> <p>If NO, consult the school/clinical psychologist and/or behavioral specialist to assist with behavioral assessment/interventions.</p>		
<p>8. After implementing the above does it appear that additional information provided through a more in-depth FBA is still needed for the student's educational achievement? Why?</p>		



***STANDARDS OF PRACTICE for***  
***Considering Functional Behavioral Assessment***

<b>Student Name:</b>	<b>School:</b>	<b>Grade:</b>
<b>Names of Participants</b>	<b>Position</b>	<b>Date:</b>
<b>Completed by:</b>		

***STANDARDS OF PRACTICE for  
Considering an Emotional Behavioral Assessment***

The *Standards of Practice* are intended to be utilized by the school to collect and analyze data and to discuss if more information is needed for the IEP/MP teams to determine the need for the specific service. They are not to be used to pre-determine services in the IEP/MP.

- **An Emotional Behavioral Assessment (EBA) is an intensive diagnostic assessment that most likely results in a clinical formulation and diagnosis.**
- **It requires consultation with a school or clinical psychologist PRIOR to determination to conduct it.**
- **An EBA may be considered after external factors and supports have been addressed through a functional behavior assessment and implementation of a behavior support plan.**
- **A *Comprehensive EBA* is an initial assessment to determine a student's mental health needs related to educational benefit.**
- **An *EBA Annual Assessment* is utilized to determine current mental health needs and recommendations for continued DOH services or specific reasons and purposes posed by the referral question.**

<b>Section 1 The following must be considered during the consultation with the psychologist and addressed PRIOR to the Team Meeting. Gathering the appropriate data assists the team to address the need for an EBA.</b>	<b>YES</b>	<b>NO</b>
1. When behavior difficulties were noted, has the teacher tried different interventions in the classroom? Describe them:  If NO please implement.		
2. Has the teacher consulted with other teachers in school, the school counselor, or behavior specialist for assistance? What was attempted as a result of the consult?		
3. If the problem behavior escalated or interventions were not effective, did the school team conduct a Functional Behavioral Assessment (FBA)?  If NO, develop a Functional Behavioral Assessment (FBA) and a Behavior Support Plan (BSP). Refer to the FBA/BSP Guide and samples.		
4. Was the BSP implemented for a period of time and revised as needed, with documentation?  If NO, based on consultation, is there agreement that there are significant circumstances to warrant the consideration of an Emotional Behavioral Assessment? Why?		

***STANDARDS OF PRACTICE for  
Considering an Emotional Behavioral Assessment***

5. If behavior did not improve or the behavior escalated, was the complex school psychologist/clinical psychologist and/or behavioral specialist consulted to assist the school with behavioral assessment/interventions?  If YES, what was recommended and implemented?	<b>YES</b>	<b>NO</b>
6. Has the Complex School Social Worker or DOE counseling provider (school counselor, behavior specialist, psychologist) interviewed the parent(s) and completed a Structured Developmental History (SDH) to obtain other important information about the student's learning difficulties, family and living situation, cultural factors, developmental and medical history, etc.?  If YES, are there any significant factors to consider and incorporate into the IEP and/or BSP? (i.e., medical, developmental, vision difficulties)  If NO, please conduct the SDH interview and utilize data appropriately.		
7. After implementing the above does it appear that additional information provided through this assessment is still needed for the student's educational achievement? Why?		

<b>Section 2 At the Team Meeting, the Following Must be Addressed</b>	<b>YES</b>	<b>NO</b>
1. Is a psychologist or other knowledgeable counseling professional a participant in this meeting?  If NO, please arrange.		
2. Based on the review of data and other information, are the student's difficulties such that an EBA is needed to support the student's educational needs?		
3. Exactly what information does the team want to obtain from this evaluation?  If a DSM-IV diagnosis is sought, why is the diagnosis necessary?		
4. Has the team discussed and considered the future implications of the student probably receiving a diagnosis as a result of this evaluation?		

***STANDARDS OF PRACTICE for  
Considering an Emotional Behavioral Assessment***

<p>5. Have all the following been discussed with the parent?</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> The EBA will entail a parent interview to collect information about the student, family history, mental health history, medical history, family relationships, and other personal data necessary to address a possible mental health disorder.</li> <li><input type="checkbox"/> The evaluation will be made available to the parent and is a part of the student record.</li> <li><input type="checkbox"/> If student health insurance is MedQuest, student may be eligible for Department of Health Support for Emotional and Behavioral Development (SEBD) services.</li> </ul>	<b>YES</b>	<b>NO</b>
<p>6. If further assessment is indicated, is the <b>BASC-2 data</b> obtained for inclusion in the EBA?</p> <p>If NO, obtain BASC-2 data. If DOH services may be utilized, then applicable Achenbach checklists will also need to be obtained.</p>		
<p align="center">If the team has determined the need for an EBA, please complete the <b>"Referral Checklist for Emotional Behavioral Assessments, Psychiatric Diagnostic and Medication Evaluations."</b></p>		

<b>Student Name:</b>	<b>School:</b>	<b>Grade:</b>
<b>Names of Participants</b>	<b>Position</b>	<b>Date:</b>
<b>Completed by:</b>		

***STANDARDS OF PRACTICE for  
Considering Counseling***

The *Standards of Practice* are intended to be utilized by the school to collect and analyze data and to discuss if more information is needed for the IEP/MP teams to determine the need for the specific service. They are not to be used to pre-determine services in the IEP/MP.

**Counseling as an IEP/MP related service is:**

- **differentiated from regular education counseling which is available to all students on an as-needed-basis.**
- **a time-limited service based on an educational model.**
- **is focused on meeting academic and behavioral goals and objectives in the IEP or MP.**

<b>Section 1 Data Gathering and Considerations</b>	<b>YES</b>	<b>NO</b>
1. When behavior difficulties were noted, has the teacher tried different interventions in the classroom? Describe them:  If NO, please implement.		
2. Has the teacher consulted with the parents/guardians, other teachers in school, the school counselor, or behavior specialist for assistance? What was implemented as a result of the consult?  If NO, please seek consultation.		
3. If the problem behavior escalated or interventions were not effective, did the school team conduct a Functional Behavioral Assessment (FBA)?  If NO, develop a Functional Behavioral Assessment (FBA) and a Behavior Support Plan (BSP.) Please refer to the FBA/BSP Guide and samples.		
4. Does the student have an appropriate Behavior Support Plan and has it been implemented on a consistent basis by all relevant parties for at least 6 weeks?  If NO, develop or revise.		
5. Has the special education teacher/504 MP coordinator, counselor, and any relevant related service providers reviewed the data to address the following?  If NO, please review the data.		
5a. Does the BASC 2 and other data indicate significant behavioral problems that impact the student's education? Please specify:		

***STANDARDS OF PRACTICE for  
Considering Counseling***

5b. Do the patterns or trends confirm that the target behaviors are increasing?  Please specify intensity, duration, frequency:	<b>YES</b>	<b>NO</b>
5c. Does the data confirm the seriousness of the behaviors?  If NO to 5a, 5b, 5c, counseling as an IEP/MP related service may not be appropriate and other supports should be considered.		
6. Are the student's difficulties and support plan such that counseling may be the best practice for delivering evidence-based interventions?  If No, counseling as an IEP/MP related service may not be appropriate and other supports should be considered (i.e., lesser restrictive services, such as, school and community supports or more intensive levels of services.)		

<b>Section 2 At the Team Meeting, the Following Must be Addressed</b>	<b>YES</b>	<b>NO</b>
1. Is a DOE counseling professional (school counselor, behavior specialist, social worker, school/clinical psychologist) participating in this meeting?  If NO, please arrange.		
2. Based on the review of data and other information, are the student's difficulties such that counseling is needed to support the student's academic achievement?  If NO, please consider alternative supports.		
3. Are the behavioral concerns documented in the PLEP and addressed with measurable Goals and Objectives?  If NO, please revisit the IEP and address the above.		
4. Please specify the <b>primary</b> skills development the student needs: a. Social skills b. Emotional coping c. Organization/attention or d. Compliance/cooperation In what settings?		
5. Does the student's goals address generalization of the targeted skills in other settings with support?  If NO, please discuss and develop such a plan.		

***STANDARDS OF PRACTICE for  
Considering Counseling***

6. Has the team discussed with the parent that counseling may be delivered as “Integrated Services” (group, individual, in-class support, etc.) to support the student with his/her curriculum, skills, strategies, and activities throughout the day at meaningful times to maximize learning?  If NO, please discuss and document the discussion.	<b>YES</b>	<b>NO</b>
7. Has the team developed a progress monitoring plan with the inclusion of rating scales, observations, and others to track student progress?  If NO, develop a plan to monitor progress, utilizing the BASC-2 as one of the components to measure effectiveness of this service on student outcomes. Refer to the Superintendent’s 2-22-05 memo re: the BASC-2.		
8. Has the team discussed the progress monitoring plan/tools with the parent(s) or guardian(s) and indicated them on the IEP/MP?  If NO, please discuss and document the discussion.		
9. Does the student’s plan include transition to a less restrictive service as the student develops capacity? (in-class support, consultation...)  If NO, please discuss and incorporate transition in the student’s plan.		
10. Has the Complex School Social Worker or DOE counseling provider (school counselor, behavior specialist, psychologist) interviewed the parent(s) and completed a Structured Developmental History (SDH) to obtain other important information about the student’s learning difficulties, family and living situation, cultural factors, developmental and medical history, etc.?  If YES, are there any significant factors to consider and incorporate into the IEP and/or BSP? (i.e., medical, developmental, vision difficulties)  If NO, please conduct the SDH interview and utilize data appropriately.		
11. If the student requires more intensive support has Department of Health service been initiated through the Interagency Peer Review process or is DOH service being provided?  Refer to the Interagency Performance Standards and Practice Guidelines. (leave blank if not applicable)		

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## ***STANDARDS OF PRACTICE for Considering Counseling***

<p>12. Has the following been discussed with the parents?</p> <p>a. Termination of counseling as an IEP/MP related service must be considered when the IEP/MP Team determines that student is no longer in need of or eligible for services due to at least <u>one</u> of the following:</p> <p>i. Targeted behaviors have abated to a level of severity which no longer requires this level of care as documented by attainment of goals in the IEP/MP;</p> <p>ii. Student no longer meets referral criteria for this service; <i>OR</i></p> <p>iii. Student no longer meets eligibility criteria.</p> <p>b. When student has demonstrated minimal or no progress toward IEP/MP goals for a <b>three month period</b> and appropriate modifications of BSP and service plans have been made and implemented with no significant success or the student exhibits new behaviors which cannot be safely and effectively addressed through counseling services, the IEP/MP will be reconvened to look at the appropriateness of the G/Os and revised as necessary.</p> <p>If YES, please document If NO, please discuss and document.</p>	YES	NO
<p>13. If the IEP/MP Team has determined the need for Counseling as an IEP/MP related service, is a complete referral packet that includes all data considered in this decision (IEP/MP, FBA/BSP, SDH, BASC-2, attendance, grades, discipline data, consent, PWN, etc) compiled to assist the counseling provider to deliver meaningful services?</p>		

<b>Student Name:</b>	<b>School:</b>	<b>Grade:</b>
<b>Names of Participants</b>	<b>Position</b>	<b>Date:</b>
<b>Completed by:</b>		



***STANDARDS OF PRACTICE for  
Considering Parent Education, Counseling/Training***

This checklist is not to be used to pre-determine services in the IEP. It is to be used as a tool for the school to collect and analyze data and to discuss if more information is needed for the IEP team to determine the need for Parent Education, Counseling/Training.

The purpose of Parent Education, Counseling/Training is to:

- A. educate parents in understanding the special needs of their child, and;
- B. help parents acquire and practice the skills that will allow them to support the implementation of their student's IEP/MP.

<b>A. Parent Education</b>	<b>YES</b>	<b>NO</b>
<p>1. Have the parents expressed the need for education relating to understanding the nature of their child's disability?</p> <p>If YES, please list specific needs and the possible number of hours/sessions that may be needed:</p>		
<p>2. Do the parents agree to attend education sessions if offered?</p> <p>If NO, STOP and proceed to B. If YES, continue.</p>		
<p>3. Have community and school-level resources that can be utilized, deployed, assigned or re-assigned to meet the need for parent education been exhausted? (ie: community parenting classes, counselor, BS, SLP, PCNC, Psychologist)</p> <p>If NO, please utilize community and school-level resources. IF YES, please describe action taken.</p>		
<p>4. Have additional complex/district-level resources that can be utilized by the school or locally available district and/or state-sponsored trainings, which are appropriate to the student's disability and parent concerns, been exhausted? (ie:BS, SW, SLP, ACT, Complex Psychologist, etc.)</p> <p>IF NO, please seek complex/district level consultation and/or give the parent a schedule of district and/or state-sponsored trainings. IF YES, please describe action taken.</p>		
<b>B. Parent Counseling/ Training</b>		
<p>5. Have the parents expressed a need for help in the acquisition and practice in the skills that will allow them to support their student's educational progress? If YES, please list specific needs and the possible number of hours/sessions that may needed?</p>		

***STANDARDS OF PRACTICE for  
Considering Parent Education, Counseling/Training***

<p>6. Have the parents attempted various strategies in the home to address the concerns expressed in #5?</p> <p>If YES, list and indicate if strategies were successful or not:</p>	<p><b>YES</b></p>	<p><b>NO</b></p>
<p>7. Do the parents agree to attend counseling/training sessions if offered?</p> <p>If YES, continue</p> <p>If NO, and student may need additional home/family support, develop strategies with parents and implement, seek consultation, or consider alternative supports and interventions.</p>		
<p>8. Have community, school and complex/district level resources that can be utilized, deployed, assigned or re-assigned to meet the need for parent counseling/training been exhausted? (ie: community parenting or training classes, counselor, BS, SLP, , PCNC, ACT, SW, Psychologist)</p> <p>If NO, please utilize community, school and complex/district-level resources. IF YES, please describe action taken.</p>		
<p>9. If school-based behavioral supports/services including parent education, counseling/training have been provided and the student and/or family issues are unmanageable, have time-limited intensive family and community-based interventions been considered?</p> <p>If NO, conduct an Interagency Peer Review to discuss possible need for intensive DOH services to support the student and family.</p>		

<b>Student Name:</b>	<b>School:</b>	<b>Grade:</b>
<b>Name of Participant</b>	<b>Position</b>	<b>Date:</b>
<b>Completed by:</b>		

***STANDARDS OF PRACTICE for***

***Considering the need for personnel to lead and direct a Skills Trainer***

<b>This checklist is to be used as a tool for the school to determine the need for personnel to lead and direct a Skills Trainer.</b>	<b>YES</b>	<b>NO</b>
1. Has the procurement of a skills trainer been authorized for <b>school hours</b> ?		
2. List the time and settings where the skills trainer will be working with the student during the school day:		
3. Is the teacher unable to direct the skills trainer during the school day on what is expected in terms of IEP G/Os to be worked on, classroom routine, strategies to use and data collection during the above mentioned time and settings?		
4. If the teacher cannot direct the skills trainer, have other resources at the school, complex or district been deployed to support the teacher in providing this service? (i.e., BHS, ACT, SPED RT, counselor, SLP, etc.)		
5. If the teacher is unable to direct the skills trainer, what training will be provided for the teacher to build capacity to provide this service in the future?		
6. Has the procurement of a skills trainer been authorized for <b>non-school hours</b> ?		
7. List the time and settings where the skills trainer will be working with the student during the non-school hours:		
8. Is the teacher unable to direct the skills trainer during non-school hours on what is expected in terms of IEP G/Os to be worked on, strategies to use and data collection during the above mentioned time and settings?		
9. If the teacher cannot direct the skills trainer during non-school hours, have other resources at the school, complex or district been considered to provide this service? (i.e., BHS, ACT, SPED RT, counselor, SLP, etc.)		

---

**INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES**

---

***STANDARDS OF PRACTICE for******Considering the need for personnel to lead and direct a Skills Trainer***

10. Are these other resources unable to provide this service during non-school hours?		
---	--	--

<b>Student Name:</b>	<b>School:</b>	<b>Grade:</b>
<b>Name of Participant</b>	<b>Position</b>	<b>Date:</b>
<b>Completed by:</b>		

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## ***STANDARDS OF PRACTICE for Considering Individualized Instructional Supports***

**This checklist is not to be used to pre-determine services in the IEP. It is to be used as a tool for the school to collect and analyze data and to discuss if more information is needed for the IEP team to determine the need for Individualized Instructional Support.**

The utilization of Individualized Instructional Supports:

- should be considered a highly restrictive intervention
- should be considered only if the student has demonstrated an inability to acquire skills in a group situation or generalize skills across multiple settings as evidenced by data.
- is to promote the student's independence and expedite/accelerate development that will lead to the student generalizing IEP goals and objectives.

### **A. Functional Life Skills Concerns**

**YES**

**NO**

1. Is the student having severe difficulties with functional life skills?  
If yes, please complete the following:  
If no, proceed to section B

2. What functional life skill listed on the student's IEP does the student have difficulty with?

- Toileting
- Mobility
- Eating
- Dressing
- Other \_\_\_\_\_

2a. What type of prompt, if any, does the student need in order to be successful in the following areas? Check the appropriate box.

SKILL	Independent (no prompts)	Gestural	Verbal	Partial Physical	Full Physical
Toileting					
Mobility					
Eating					
Dressing					
Other: (specify)					

**YES**

**NO**

3. Has data been collected consistently for at least 10 days on the student's functional life skills?  
If no, continue the student's current educational program and collect relevant data.

3a) Summarize and attach the baseline data that identifies the student's skill level on each area of concern. Include description of what the student currently can do, in what setting, how often the student will attempt the skill (example: student does not have bladder control and must have diaper changed at least hourly throughout the school day)

***STANDARDS OF PRACTICE for  
Considering Individualized Instructional Supports***

	<b>YES</b>	<b>NO</b>
<p>4. Are visual supports in place for skills that require prompting?</p> <ul style="list-style-type: none"> <li>▪ If YES, list visual supports that are in place for skills that require prompting:</li> <li>▪ If NO, assign a team member to review the possibility of increasing mini schedules or visual supports for the student in each of the areas listed in #2.</li> </ul> <p>Name of Team Member: _____</p>		
<p><b>B. Communication Concerns</b> (This section to be completed with input from the special education teacher, speech pathologist and others with relevant knowledge and data).</p>	<b>YES</b>	<b>NO</b>
<p>Are there concerns regarding the students communication skills? (ie. Pragmatics, receptive language, expressive language, articulation, hearing)</p> <p>If YES, please describe and then answer the following questions:</p> <p>If NO, proceed to section C</p>		
<p>1. Has data been collected consistently throughout a 10 day period?</p> <p>If no, continue the student's current educational program and collect relevant data. If yes, please attach data summary.</p>		
<p>2. Does the student have communication goals in the IEP? If no, please hold an IEP meeting to review/revise the IEP.</p>		
<p>3. Does the student receive services from the SLP? If no, please collaborate with the SLP regarding the communication concerns.</p>		
<p>4. Does the student have a functional, accessible method of communication at all times? (prompted responses or providing answers to questions is not an adequate level of communicative ability to prevent behavior problems)</p> <p>If yes, please describe the student's communication system:</p> <p>If no, consult and collaborate with the SLP.</p>		
<p>5. Does the student use the communication system independently to communicate needs and wants?</p>		

## ***STANDARDS OF PRACTICE for Considering Individualized Instructional Supports***

Appendix A – Document 5g

***STANDARDS OF PRACTICE for  
Considering Individualized Instructional Supports***

	<b>YES</b>	<b>NO</b>
6a. If yes, is the student showing progress in utilizing appropriate social skills?		
6b. If NO, review/revise the social skills instruction, generalization plan and collect relevant data.		
7. If yes to #6 please attach data summary.		
<b>D. Behavioral Concerns (This section to be completed with input from the special education teacher and behavior specialist or psychologist and others with relevant knowledge and data).</b>	<b>YES</b>	<b>NO</b>
Does the student have severe behaviors that interfere with academic achievement? If NO, proceed to Summary If YES, please complete the following:		
1. Identify the behavior(s) of concern:  <div style="margin-left: 40px;"> ✓ Describe what the behavior is:   ✓ Describe how it interferes with academic achievement:   ✓ State how frequently each occurs:   ✓ Setting of the occurrence:   ✓ Time of day of occurrences:   ✓ How long does each behavior last:   ✓ How serious is the concern for each behavior:   ✓ Is the behavior(s) a danger to self and/or others?   ✓ Has the behavior(s) resulted in disciplinary actions? </div>		
2. Has quantifiable data been taken on all behaviors of concern for at least 10 school days? If No: DO IT NOW! Take measurable data for baseline.  2a. If YES, Review the data. Answer the following questions: What patterns or trends does the data show? Is the target behavior(s) increasing, decreasing, staying the same? Attach comments		



***STANDARDS OF PRACTICE for  
Considering Individualized Instructional Supports***

	<b>YES</b>	<b>NO</b>
3. Does the data confirm behavioral concerns expressed in #1?		
4. Has the special education teacher, administrator and any relevant related service provider reviewed the data? (ie: ACT, BHS, School Complex Psychologist) If No, Review the data. Answer the following questions: What patterns or trends does the data show? Is the target behavior(s) increasing, decreasing, staying the same?		
5. Does the student have an Functional Behavioral Assessment (FBA)? If No, begin the process to complete an FBA for the student.		
5a. If Yes, is the FBA updated and currently relevant? If No, review/revise the FBA.		
6. Does the student have a Behavior Support Plan (BSP)? If No, complete a BSP for the student.		
7. Does the student have measurable behavior goal(s) in the IEP? If no, convene an IEP meeting to review/revise the IEP.		
8. Have behavioral interventions stated in the BSP been consistently implemented for at least 6 weeks?		
8a. Has data been collected consistently throughout the 6-week period? If no, review/revise BSP and collect relevant data. If yes, please attach data summary.		
<b>Summary</b>	<b>YES</b>	<b>NO</b>
1. Does the student need individualized instructional support beyond what is already assigned to the classroom? If yes, what areas does the student need additional support? Please check: <ul style="list-style-type: none"> <li>○ Functional Life Skills</li> <li>○ Communication</li> <li>○ Social Skills</li> <li>○ Behavior</li> </ul>		

***STANDARDS OF PRACTICE for  
Considering Individualized Instructional Supports***

<p>2. Specify the proposed frequency, times and environment for each area marked in #3:</p> <ul style="list-style-type: none"><li>○ Functional Life Skills _____</li><li>○ Communication _____</li><li>○ Social Skills _____</li><li>○ Behavior _____</li></ul>
<p>3. Specify the proposed duration of support needed for each area:</p> <ul style="list-style-type: none"><li>○ Functional Life Skills _____</li><li>○ Communication _____</li><li>○ Social Skills _____</li><li>○ Behavior _____</li></ul>
<p>4. Will the support be provided: check one</p> <ul style="list-style-type: none"><li>○ to care for the student's basic needs?</li><li>○ or will it be provided with the intent to teach the skill?</li></ul>
<p>5. Attach a fading plan to reduce the dependency and eliminate the need for individualized support in each area.</p>
<p>6. When considering individualized instructional support beyond the school day, does the school have documentation to justify an extension of the school day? The team should apply the Extended School Year (ESY) standard. Attach data that documents the parameters of the ESY standards and the need for support beyond the school day.</p>
<p>7. When contemplating the need for ESY supports, is there strong evidence that the school day has been maximized with effective interventions and ample opportunities across instructional settings? Please describe</p>

***STANDARDS OF PRACTICE for  
Considering Individualized Instructional Supports***

8. Please indicate potential staff that will be providing the individualized instructional support in needed areas: (identify by position)

- ☐ Functional Life Skills \_\_\_\_\_
- ☐ Communication \_\_\_\_\_
- ☐ Social Skills \_\_\_\_\_
- ☐ Behavior \_\_\_\_\_

9. Staff responsible for leading and directing the activities of the individual providing the support if the person providing the support is a paraprofessional:

\_\_\_ Teacher (specify position: \_\_\_\_\_)

\_\_\_ Other school personnel (specify position: \_\_\_\_\_)

\_\_\_ Other (specify hours per week/month \_\_\_\_\_)

<b>Student Name:</b>	<b>School:</b>	<b>Grade:</b>
<b>Name of Participant</b>	<b>Position</b>	<b>Date:</b>
<b>Completed by:</b>		

***STANDARDS OF PRACTICE for  
Considering Medication Management and Procurement Procedures***

<b>Medication Management is:</b> <ul style="list-style-type: none"> <li>• The ongoing assessment of the student's response to medication, symptom management, side effects, and adjustment in medication or dosage and</li> <li>• A time-limited service to be integrated with emotional/behavioral health services and not as a stand-alone medical service.</li> </ul>		
--	--	--

<b>Section 1. For Medication Management procurement, the following requirements must be met.</b>	<b>YES</b>	<b>NO</b>
--	------------	-----------

1. Based on the findings of the Psychiatric Evaluation, Emotional/Behavioral Assessment and other educational data, the student needs prescription and administration of medication:		
a. to address mental health needs and to augment the student's behavior support plan and emotional, behavioral or mental health services,		
b. to prevent need for a more restrictive or intensive service level, and		
c. to monitor for effectiveness, adverse reactions and the renewing of prescriptions at frequencies consistent with accepted practice.		

**Are ALL three requirements met? If YES, please continue.  
If NO, other alternatives, resources and supports should be recommended.**

**Target Population:**

2. The student must:		
a. have or is suspected of having a disability described in IDEA or Section 504 and		
b. be currently exhibiting moderate to severe social, communication, emotional or behavioral deficits and		
c. be in need of behavioral or mental health services in order to benefit from his/her free and appropriate public education.		

**Are ALL three requirements met? If YES, please continue.  
If NO, other alternatives, resources and supports should be recommended.**

<b>Section 2. At the Team Meeting, the parents must be informed of the following PRIOR to procurement:</b>	<b><u>YES</u></b>	<b><u>NO</u></b>
--	-------------------	------------------

Parents may utilize a private physician through their insurance plan (broader range of provider choices, more options related to location of provider, greater flexibility in scheduling and scope of service, parent ownership of the psychiatric medication management progress reports, etc.)		
--	--	--

***STANDARDS OF PRACTICE for  
Considering Medication Management and Procurement Procedures***

1. DOE provided medication management services are procured from DOE contracted providers whose psychiatric progress reports are part of the student's record.	<b>YES</b>	<b>NO</b>
2. Acceptance of DOE medication management may affect the student's/parent's insurance benefits (i.e., denial of member rates for medication.) Checking with the insurance provider is the parent's/guardian's responsibility.		
3. Ongoing DOE medication management requires discussion between the provider and the school personnel regarding the student's adjustment.		
4. DOE contemplates that the average session will take three (3) units (15 minutes) to complete. Medication management is limited to 12 units (60 minutes) per session or frequencies consistent with accepted practices.		
5. Medication management occurs at least monthly during the first three (3) months of initiation of any medication (and may occur more frequently if so documented by the treating physician).		
6. Medication management occurs at least quarterly, once the provider and the school document that the medications are effectively regulating the emotional-behavioral condition.		
7. Provision of this service must be time-limited.		
8. Additional units may be requested by the provider via the submittal of written specific justification of need and written authorization is given by the appropriate SBBH or ASD District Educational Specialist.		
9. Termination of DOE provided medication management must be considered by the IEP team when:		
a. The student's condition has stabilized and the symptoms have reduced in frequency and severity and medication has been discontinued;		
b. The student and family no longer desire psychopharmacological interventions and have withdrawn consent; or		
c. The student no longer meets relevant eligibility criteria. As part of the transition, the physician will transfer the student to appropriate treatment services in the least disruptive manner possible, in a collaborative and coordinated manner.		

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### ***STANDARDS OF PRACTICE for Considering Medication Management and Procurement Procedures***

10. Based on discussion of all the above, does the parent choose to have DOE contracted medication management?	<b>YES</b>	<b>NO</b>
<p style="text-align: center;"><b><i>Discuss ALL items with the parent/guardian and document.</i></b></p> <p><b><i>If there are concerns that are not addressed above, please seek consultation with District staff.</i></b></p> <p><b><i>If ALL responses to the above are YES, please attach the BSP and complete the Request for Provider Form which requires DES/District Designee signature for payment with District funds.</i></b></p>		

<b>Student Name:</b>	<b>School:</b>	<b>Grade:</b>
<b>Names of Participants in the procurement decision</b>	<b>Position</b>	<b>Date:</b>
<b>Submitted to DES by:</b>	<b>Date submitted:</b>	

<b>FUNDING SOURCE</b> (To be completed by the District Educational Specialist)
<div style="margin-bottom: 10px;"> <input type="checkbox"/> All Standards of Practice and Procurement Procedures were answered YES.             <input type="checkbox"/> All Standards of Practice and Procurement Procedures were <b>NOT</b> answered YES.           </div> <p>If all Standards of Practice and Procurement Procedures were <b>NOT</b> answered YES, school funds may be utilized to pay for contracted services. The school will be notified the amount to LSB-3 to the appropriate Program ID.</p>
<div style="margin-bottom: 10px;"> <input type="checkbox"/> Payment via District Funds      ( ) ASD      ( )SBBH      ( ) Other (IDEA)             <input type="checkbox"/> No Payment via District Funds           </div> <div style="display: flex; justify-content: space-between; margin-bottom: 10px;"> <div style="width: 45%;">             _____              Name of District Ed Specialist           </div> <div style="width: 45%;">             _____              Signature of District Ed Specialist           </div> </div> <p>Date: _____</p>
School was notified of the Assignment of Funding Source and where to send the referral packet on: Date _____

***STANDARDS OF PRACTICE for  
Considering Psychiatric Diagnostic and Medication Evaluations***

**The Psychiatric Diagnostic and Medication Evaluations are Emotional Behavioral Assessments (EBA) with a medical component. Consultation with a school or clinical psychologist is required PRIOR to the determination to conduct these as they are intensive diagnostic assessments that result in a clinical formulation and diagnosis.**

- **The student must have or is suspected of having a disability described in IDEA or Section 504 and is currently exhibiting moderate to severe social, communication, emotional or behavioral deficits and is in need of emotional/behavioral or mental health services in order to benefit from his/her free and appropriate public education.**
- ***The Psychiatric Diagnostic Evaluation* is for a medically complex or diagnostically complex student.**
- ***The Psychiatric Medication Evaluation* is also diagnostic and assesses the student's presenting symptoms for the purpose of possible prescription and administration of medication to address mental health needs and to augment emotional/behavioral health services in a student's behavior support plan.**

**Section 1 The following must be considered during the consultation with the psychologist and addressed PRIOR to the Team Meeting. Gathering the appropriate data assists the team to address the need for the above evaluations.**

**YES NO**

1. Is the student currently exhibiting moderate to severe social, communication, emotional or behavioral deficits and receiving emotional/behavioral or mental health services in order to benefit from his/her free and appropriate public education?

If YES, what are the behaviors and what emotional/behavioral or mental health service is the student receiving to address his educational needs?

If NO, the student may not be eligible for this service. If the student may need behavioral/mental health services, refer to other Standards of Practice, i.e., for Considering Counseling.

2. Are the student's behaviors suggestive of a DSM IV diagnosis for which medication interventions may be needed to **augment** a behavior support plan and **emotional/behavioral health services** ?

If YES, what are the behaviors; how do they impact academic achievement and to what degree?

If NO, develop/refine the Functional Behavior Assessment (FBA) and Behavior Support Plan (BSP)

***STANDARDS OF PRACTICE for  
Considering Psychiatric Diagnostic and Medication Evaluations***

	YES	NO
3 a. Is there a current EBA, Medication or Psychiatric Evaluation (within one calendar year) with recommendations for medication interventions? or		
b. Is there agreement that there are significant circumstances to warrant the consideration of a Psychiatric Medication Evaluation? What are the significant circumstances? or		
c. Is there agreement that the student's needs appear to be <b>psychiatrically or medically complex</b> to warrant the consideration of a Psychiatric Diagnostic Evaluation?		
If NO to 3a, 3b, and 3c (all), please review Standards of Practice for FBA/BSP or EBA. If YES to 1, 2, and 3, please address Section 2 below at the IEP meeting.		

<b>Section 2 At the Team Meeting, the Following Must be Addressed</b>	YES	NO
1. Is a psychologist or other knowledgeable behavioral health professional a participant in this meeting?  If NO, please arrange.		
2. Based on the review of data and other information, are the student's difficulties such that a Psychiatric Medication Evaluation is needed.  If YES, skip the Questions #3 and 4.		
3. Based on the review of data and other information, are the student's difficulties psychiatrically or medically complex such that a Psychiatric Diagnostic Evaluation is needed.  If NO to questions #2 and 3, psychiatric evaluations are not warranted.		
4. Exactly what information does the team want to obtain from the Psychiatric Diagnostic Evaluation?  If a DSM-IV diagnosis is sought, why is the diagnosis necessary?		
5. Has the team discussed and considered the future implications of the student probably receiving a diagnosis as a result of this evaluation?		
6. Have <b>all</b> the following been discussed with the parent? <input type="checkbox"/> The evaluation will entail a parent interview to collect information about the student, family history, mental health history, medical history, family relationships, and other personal data necessary to address a possible mental health disorder.		



## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### ***STANDARDS OF PRACTICE for Considering Psychiatric Diagnostic and Medication Evaluations***

<ul style="list-style-type: none"> <li><input type="checkbox"/> Parents may utilize a private physician through their insurance plan (broader range of provider choices, greater flexibility in scheduling and scope of service, parent ownership of the evaluation with summary shared with the DOE, etc.)</li> <li><input type="checkbox"/> DOE Psychiatric Evaluation may result in a prescription for medication. Use of that prescription may affect the student's/parent's insurance benefits (i.e., denial of member rates on medication.) It is the parent's/guardian's/caregiver's responsibility to check with the insurance provider.</li> <li><input type="checkbox"/> DOE provided medication management is a time-limited service must be integrated with emotional-behavioral health services and is not a stand-alone medical service.</li> <li><input type="checkbox"/> DOE psychiatric evaluations procured from DOE contracted providers are part of the student record and will be made available to parent/guardian..</li> <li><input type="checkbox"/> If student health insurance is MedQuest, student may be eligible for Department of Health Support for Emotional and Behavioral Development (SEBD) services</li> </ul>	<b>YES</b>	<b>NO</b>
<p>7. If either Psychiatric Diagnostic or Medication Evaluation is determined to be needed, has current <b>BASC-2 data</b> been obtained for inclusion in the evaluation? If DOH services may be utilized, then applicable Achenbach checklists will also need to be obtained.</p>		
<p><b><i>If the team has determined the need for a Psychiatric Evaluation, please complete the Referral Checklist for EBA, Psychiatric Diagnostic and Medication Evaluations.</i></b></p>		

<b>Student Name:</b>	<b>School:</b>	<b>Grade:</b>
<b>Names of Participants</b>	<b>Position</b>	<b>Date:</b>
<b>Completed by:</b>		

***STANDARDS OF PRACTICE for  
Considering Intensive Learning Center (formerly CBI)***

The *Standards of Practice* are intended to be utilized by the school to collect and analyze data and to discuss if more information is needed for the IEP/MP teams to determine the need for the specific service or placement. They are not to be used to pre-determine services in the IEP/MP.

<b>Section 1 Data Gathering and Considerations.</b>	<b>YES</b>	<b>NO</b>
1. If the student has a Section 504 modification plan and is believed to require Intensive Learning Center program/placement, has an IDEA evaluation been considered and initiated?  If NO, initiate IDEA evaluation or justify why not:		
2. Drug use is NOT a primary factor in educational concerns.  If NO, consult with DOH and schedule a peer review meeting to discuss service options.		
3. Does the IEP reflect the student's <i>current</i> (within the last quarter) functioning?  If NO, please address this through the IEP process.		
4. Are the academic and behavioral concerns documented in the PLEP and addressed with measurable Goals and Objectives?  If NO, please address this through the IEP process.		
5. Are the special education and related services provided to the student appropriate to the goals and objectives?  If NO, please address this through the IEP process.		
6. Is the IEP being implemented consistently and with integrity? For example, has the student been receiving the indicated IEP services in a timely manner including all necessary IEP elements of intervention?  If NO, implement appropriately.		
7. If the problem behavior has escalated or interventions were not effective, did the school team conduct a Functional Behavioral Assessment (FBA)?  If NO, please conduct an FBA. Refer to the FBA/BSP Guide and samples.		
8. Is the FBA updated and/or currently relevant?  If NO, please update the FBA.		
9. Was the BSP implemented for an adequate period of time and revised as needed, with documentation?  If NO, implement the BSP with integrity and documentation.		

***STANDARDS OF PRACTICE for  
Considering Intensive Learning Center (formerly CBI)***

<p>10. If the behavior did not improve or the behavior escalated, was the complex school psychologist/clinical psychologist and/or behavioral specialist consulted to assist the school with behavioral assessment/interventions?</p> <p>If YES, what was recommended and implemented?</p> <p>If NO, seek consultation and document what was recommended, implemented, and progress made.</p>		
<p>11. Has the parent(s) or guardian(s) been interviewed for the completion of the Structured Developmental History (SDH) to obtain other important information about the student's learning difficulties, family and living situation, cultural considerations, developmental and medical history, etc?</p> <p>If YES, are there any significant factors to consider and incorporate into the IEP and/or BSP? (i.e., medical, developmental, vision difficulties)</p> <p>If NO, please conduct the SDH interview and utilize data appropriately.</p>		
<p>12. Have the BASC-2 components been administered and have results been reviewed by the team?</p> <p>If NO, complete the BASC-2 instruments and review results. Refer to the Superintendent's memo re: Basc-2 Implementation, dated 2-22-05.</p>		
<p>13. Does the data indicate significant behavioral problems that impact the student's education and confirm that serious target behaviors are increasing?</p> <p>If NO, through the IEP process, consider alternative services and programs.</p>		
<p>14. Using the data, have you discussed and defined the actual seriousness of the behaviors?</p> <p>If NO, use data and define the serious behaviors</p>		
<p>15. Does the student have a current (within one year) Emotional Behavioral Assessment or psychiatric assessment?</p> <p>If NO, conduct or update the EBA.</p>		
<p>16. Have the student's current needs been discussed at a peer review and have DOH services been considered or provided?</p> <p>If NO, conduct an Interagency Peer Review to discuss possible need for intensive DOH services to support the student and family.</p>		

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### ***STANDARDS OF PRACTICE for Considering Intensive Learning Center (formerly CBI)***

17. Has there been a peer review with complex based and/or district psychologist present to consider the appropriateness of a possible ILC placement.  If NO, schedule this peer review and have all relevant data available for team to review.	YES	NO
18. Is there agreement that there is sufficient data for the IEP team to consider ILC placement?  If YES, address Section 2 below at the IEP meeting. If NO, reconvene the IEP team to discuss other options/ Recommendations.		

<b>Section 2 Questions to Consider/Address at the IEP Team Meeting</b>	<b>YES</b>	<b>NO</b>
1. Is a representative of the ILC a participant at the IEP meeting?		
2. If the team meets, reviews and revises the IEP and determines that the student requires placement in a more restrictive environment, is it based on data and consultation with the appropriate professionals?		
3. Are the academic and behavioral concerns documented in the PLEP and addressed with measurable Goals and Objectives?		
4. Has the team developed a progress monitoring plan with the inclusion of rating scales, observations, and others to track student progress?		
5. Has the team discussed the progress monitoring plan/tools with the parent(s) and indicated them on the IEP/MP?		
6. As placement in the program is time-limited, has the team developed a timeframe and plan to integrate the student into a less restrictive environment?		
7. Is the above timeframe and plan documented in the BSP and conference notes?		
8. Is the data used to determine this placement clearly cited in the PWN addressing placement?		
9. The ILC placement will be monitored by _____ and how often? _____		

<b>Student Name:</b>	<b>School:</b>	<b>Grade:</b>
<b>Names of Participants</b>	<b>Position</b>	<b>Date:</b>
<b>Completed by:</b>		

***STANDARDS OF PRACTICE for  
Considering a Special School***

<p><b>This checklist is not to be used to pre-determine services in the IEP. It is to be used as a tool for the school to collect and analyze data and to discuss if more information is needed for the IEP team to determine the need for possible placement in a Special School.</b></p>		
<p>The purpose of a Special School is to provide a public separate facility for students in need of a more restrictive setting than is usually available on a public school campus for students exhibiting a combination of severe social, communication and behavioral deficits.</p>	<b>YES</b>	<b>NO</b>
<p>1. Does the IEP reflect the students current functioning across domains? (academic, communication, social, life skills and behavior)</p> <p style="padding-left: 40px;">If NO, please revise/review the IEP to reflect students current functioning.</p>		
<p>2. Are the social, communication and behavioral concerns documented in the PLEP and addressed with measurable goals and objectives?</p> <p style="padding-left: 40px;">If NO, please revise/review the IEP.</p>		
<p>3. Is the IEP being implemented consistently?</p>		
<p>4. Does the student have an FBA that is updated and relevant?</p> <p style="padding-left: 40px;">If NO and the student is being considered for this intensive placement, please conduct or update the FBA.</p>		
<p>5. Does the student have a BSP that is updated and relevant?</p> <p style="padding-left: 40px;">If NO and the student is being considered for this intensive placement, please conduct or update the BSP.</p>		
<p>6. Was the BSP implemented for a minimum of 6 weeks and data collected?</p> <p style="padding-left: 40px;">IF NO, implement the BSP and collect data.</p>		

***STANDARDS OF PRACTICE for  
Considering a Special School***

<p>7. If the behavior(s) did not improve or the behavior(s) escalated, was the complex school psychologist/clinical psychologist, BHS and/or the ACT consulted to assist the school?</p> <p>If NO, please consult the appropriate personnel.</p> <p>If YES, what was recommended and attempted?</p>		
	<b>YES</b>	<b>NO</b>
<p>8. Using all of the data, has the school discussed and defined the actual seriousness of the behavior(s)?</p> <p>IF NO, use data and define the serious behavior(s).</p>		
<p>9. Is there agreement that there is sufficient data to take to the IEP team for consideration of Special School placement?</p> <p>If NO, revise/review IEP to discuss other options and/or recommendations.</p>		

<b>Student Name:</b>	<b>School:</b>	<b>Grade:</b>
<b>Name of Participant</b>	<b>Position</b>	<b>Date:</b>
<b>Completed by:</b>		

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

<i><b>FBA and BSP GUIDE</b></i>		
ASSESS	A. Referral	1. Define referral concerns or questions in clear behavioral terms: a. How does the behavior interfere with learning? b. What interventions have been tried and what are their outcomes?
	B. Collect information	1. Collect informal observation data. 2. Collect structured observation data. 3. Do functional behavior assessment; include key individuals (esp. parent or family member).
	C. Identify key behavioral influences	1. Define problem (target) behavior(s) in observable terms. 2. Identify triggering antecedents (fast triggers or immediate context). 3. Identify possible setting events (slow triggers or background context). 4. Identify perceived function of the problem behavior(s). 5. Identify actual consequences. 6. Develop summary statements regarding behavioral influences (hypothesis). 7. Determine level of agreement or confidence that individuals have in resulting summary statement.
	D. Confirm hypothesis statement (if #C7 confidence level is low)	1. Collect formal direct observation information on behavior(s), fast triggers, and consequences. 2. Determine if direct observation data confirm hypothesis statement(s).
PLAN	E. Identify behavior goals	1. Identify preferred positive replacement behavior (long-term goal). 2. Identify acceptable interim replacement behaviors that fulfill perceived function (short-term objectives).
	F. Identify strategies for Behavior Support Plan (BSP)	1. Select strategies, environmental manipulations, or both that prevent or address slow triggers. 2. Select strategies, environmental manipulations, or both that prevent or address fast triggers. 3. Identify instructional strategies necessary to teach skill sequences required for replacement behaviors. 4. Identify strategies that reinforce the use of appropriate behavior. 5. Identify strategies that provide consequences for undesired behavior. 6. Develop crisis prevention and intervention procedures. 7. Assure that intervention strategies are consistent with family and cultural values.
IMPLEMENT	G. Implement BSP	1. Identify persons who will implement BSP goals. (These persons should be part of plan development.) 2. Develop specifics for implementation of BSP. 3. Determine what resources are needed to implement BSP. 4. Provide necessary staff and family supports, training and resources.
EVALUATE	H. Evaluate and monitor plan effectiveness	1. Develop evaluation procedures and timeline to assess success of BSP. 2. Implement evaluation procedures to assess success of BSP. 3. Review progress according to schedule set in H1. 4. Return to earlier steps as needed.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### Functional Behavior Assessment Sample

**STRENGTHS:**

Student is intelligent, artistic, creative, articulate, caring/empathic and has a supportive family

SLOW TRIGGERS	FAST TRIGGERS	PROBLEM BEHAVIOR	PERCEIVED FUNCTION	ACTUAL CONSEQUENCES
<ul style="list-style-type: none"> <li>• ADHD</li> <li>• Specific Learning Disabilities</li> <li>• Auditory Processing Disorder</li> <li>• Mood lability</li> <li>• Poor social skills</li> <li>• Hypersensitivity to perceived criticism</li> <li>• High background noise</li> </ul>	<ul style="list-style-type: none"> <li>• Work perceived as difficult</li> <li>• Journal assignment</li> <li>• Being confronted with a rule he disagrees with</li> <li>• Perceived/actual slight</li> <li>• Perceived/actual insult</li> <li>• Perceived threat</li> <li>• Other student gets too close or initiates unwanted touch (purposeful or accidental)</li> </ul>	<p>1) Work refusal</p> <p>2) Physical or verbal altercations with other students: push or hit, inappropriate comments and profanity.</p>	<ul style="list-style-type: none"> <li>• Avoidance of work</li> <li>• Avoidance of looking "stupid" to self or others</li> <li>• Gaining control</li> <li>• Assert self</li> <li>• Assert control</li> <li>• Retribution</li> </ul>	<ul style="list-style-type: none"> <li>• Avoidance of work</li> <li>• Loss of recess until work is completed</li> <li>• Negative attention from peers/adults</li> <li>• Loss of privileges</li> <li>• Referral to principal (if severe incident)</li> </ul>



## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

*This form is to FACILITATE the PROCESS to DEVELOP a plan.*

### Behavior Support Plan Brainstorming

STUDENT: Sample Student

DATE: 4/17/2004

<b>When (Setting, events, antecedents)</b> 1. Student is given an assignment that he perceives as difficult (Such as a journal assignment) 2. He also has a strong sense of justice or fairness, and is most comfortable when he can predict expectations. Thus, he may also reject assignments when procedures or rules are changed (e.g., when he was told he could no longer take his journal to other classes to complete.				
<b>Student does (Problem Behavior)</b> 1. Refuses to do assignment 2. Has physical or verbal altercations with peers				
<b>in order to (get/avoid; function)</b> 1. Avoid doing the work 2. Assert control or to get retribution				
PREVENT/ADDRESS SLOW TRIGGERS	PREVENT/ADDRESS FAST TRIGGERS	SKILLS TO TEACH	REINFORCEMENT	CONSEQUENCES FOR UNDESIRED BEHAVIOR
<ul style="list-style-type: none"> <li>Academic skills building</li> </ul>	<ul style="list-style-type: none"> <li>Maintain consistent rules</li> <li>Maintain consistent expectations</li> <li>Provide assignments at appropriate instructional levels</li> <li>Provide structured transition with time to settle</li> <li>Adjust assignments</li> </ul>	<ul style="list-style-type: none"> <li>Academic skills</li> <li>Asking for help</li> <li>Communicating difficulty of assignment</li> </ul>	<ul style="list-style-type: none"> <li>Reward completed assignments (whenever they are completed, regardless of attitude) with stars or stickers</li> <li>Reward accumulation of stars or stickers with choice activities, classroom privileges or responsibilities, possibly with phoning mother to tell her good news</li> </ul>	<ul style="list-style-type: none"> <li>Loss of recess until work is completed</li> </ul>

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### Behavior Support Plan Implementation

STUDENT: **Sample**

DATE: **4/17/2004**

<b>LONG-TERM MEASURABLE GOALS:</b> (including Preferred Positive Replacement Behaviors)		<b>TARGET DATE</b>
1) When given an assignment at his instructional level, student will complete 90% of the assignment within timelines set by teacher for one month.		10/31/04 12/31/04
2) When student has peer relationship problems, he will use problem-solving and conflict resolution strategies 90% of the time and have no altercations noted or brought to the attention of school staff for two months.		
<b>SHORT-TERM MEASURABLE OBJECTIVES:</b> (including Acceptable Interim Replacement Behaviors)		<b>TARGET DATE</b>
1 a) When given an assignment at his instructional level, student will complete 75% the assignment within timelines set by teacher for one week.		5/31/2004 5/31/2004
2 a) When student believes he has been slighted, insulted or threatened by a peer, he will remove himself from the interaction prior to engaging in an altercation at least twice per week.		
2b) Student will demonstrate appropriate problem-solving strategies during role-plays with counselor 75% of the time.		5/31/2004
<b>BASELINE MEASURE</b> (starting skills or behaviors)	<b>DATA COLLECTION TO MEASURE PROGRESS</b> (what/when/where/how)	<b>PERSON(S) RESPONSIBLE</b>
1) During the past month, student has completed 65% of his assignments within timelines set by the teacher.  2) Physical altercations occur about once per month. Verbal altercations average twice per day. He seeks no adult support prior to these altercations.	1) When assignments are collected, teacher will mark whether the assignment was completed on time in her grade book.  2a Teacher will keep event log of all physical and verbal altercations.  2a Observation using the BASC-2 SOS to gather data on standard categories and regarding use of problem-solving and conflict resolution skills in the settings where altercations are most frequent.	1) Teacher  2) Teacher and Vice Principal
<b>INTERVENTIONS</b> (what/when/where/how)	<b>PERSON(S) RESPONSIBLE</b>	<b>REVIEW NOTES</b> (degree of success)
Teacher will assure class assignments are at instructional level.	Teacher	

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

INTERVENTIONS (what/when/where/how)\	PERSON(S) RESPONSIBLE	REVIEW NOTES (degree of success)
Teaching activities and instructions should present visual and auditory material sequentially rather than at the same time.	Teacher	
Team shall apply consequences consistently.	Teacher and Vice Principal	
Counselor will teach problem-solving skills and conflict-resolution skills through role-playing.	Counselor	
Teacher and counselor will provide opportunities to learn, apply, and practice social skills in a group setting.	Teacher and Counselor	

Expected Review Dates: \_\_\_\_\_

Copies to: Parent

SSC/IEP/MP Coordinator

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

*This form is to FACILITATE the PROCESS to DEVELOP a plan.*

### Functional Behavior Assessment

STUDENT:

DATE:

STRENGTHS:

SLOW TRIGGERS	FAST TRIGGERS	PROBLEM BEHAVIOR	PERCEIVED FUNCTION	ACTUAL CONSEQUENCES

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

*This form is to FACILITATE the PROCESS to DEVELOP a plan.*  
Behavior Support Plan Brainstorming

STUDENT:

DATE:

When student does				
in order to (get/avoid)				
PREVENT/ADDRESS SLOW TRIGGERS	PREVENT/ADDRESS FAST TRIGGERS	SKILLS TO TEACH	REINFORCEMENT	CONSEQUENCES FOR UNDESIREDBEHAVIOR

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

*This form is to FACILITATE the PROCESS to DEVELOP a plan.*

### Behavior Support Planning Worksheet

Name:

School:

Date:

**Recommended Behavioral Interventions:**

	Primary responsibility	Implementation date	Measure of success
Setting Event Interventions:  <i>What can be done to eliminate or reduce the effect of setting events on the problem behaviors?</i>			
Antecedent (fast trigger) interventions:  <i>What can be done to eliminate or reduce the effect of specific classroom (or home based) triggers on problem behaviors?</i>			

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

	Primary responsibility	Implementation date	Measure of success
Alternative/replacement behavioral interventions: <i>What new skills need to be taught for the student to achieve alternative behaviors?</i>			
Consequence Strategies: Maintaining consequences: <i>What will the response be to the desired behavior?</i>			
Reduction Oriented Consequences: <i>What will the response be to the problem behavior?</i>			

Next Meeting Date

**INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES**

*This form is to FACILITATE the PROCESS to DEVELOP a plan.*  
**Behavior Support Plan Brainstorming**

**STUDENT:**

**DATE:**

When student does				
in order to (get/avoid)				
PREVENT/ADDRESS SLOW TRIGGERS	PREVENT/ADDRESS FAST TRIGGERS	SKILLS TO TEACH	REINFORCEMENT	CONSEQUENCES FOR UNDESIREDBEHAVIOR



---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

*This form is to FACILITATE the PROCESS to DEVELOP a plan.*

### Behavior Support Planning Worksheet

Name:

School:

Date:

**Recommended Behavioral Interventions:**

	Primary responsibility	Implementation date	Measure of success
Setting Event Interventions:  <i>What can be done to eliminate or reduce the effect of setting events on the problem behaviors?</i>			
Antecedent (fast trigger) interventions:  <i>What can be done to eliminate or reduce the effect of specific classroom (or home based) triggers on problem behaviors?</i>			

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

	Primary responsibility	Implementation date	Measure of success
Alternative/replacement behavioral interventions: <i>What new skills need to be taught for the student to achieve alternative behaviors?</i>			
Consequence Strategies: Maintaining consequences: <i>What will the response be to the desired behavior?</i>			
Reduction Oriented Consequences: <i>What will the response be to the problem behavior?</i>			

Next Meeting Date

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### BEHAVIOR SUPPORT PLAN IMPLEMENTATION

STUDENT:

DATE:

LONG-TERM MEASURABLE GOALS: (INCLUDING PREFERRED POSITIVE REPLACEMENT BEHAVIORS)		TARGET DATE
SHORT-TERM MEASURABLE OBJECTIVES: (INCLUDING ACCEPTABLE INTERIM REPLACEMENT BEHAVIORS)		TARGET DATE
BASELINE MEASURE (STARTING SKILLS OR BEHAVIORS)	DATA COLLECTION TO MEASURE PROGRESS (WHAT/WHEN/WHERE/HOW)	PERSON(S) RESPONSIBLE
INTERVENTIONS (WHAT/WHEN/WHERE/HOW)	PERSON(S) RESPONSIBLE	REVIEW NOTES (DEGREE OF SUCCESS)

Expected Review Dates: \_\_\_\_\_

Copies to: Parent

SSC/ IEP/MP coordinator

BSPI

8/31/04

---

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

## Department of Education Guidelines for Water-Related Activities

### Regulations

1. Planning for water-related activities shall include (see DOE memo dated June 23, 2004):
  - a. Objectives clearly related to Individualized Education Program/Modification Plan (IEP/MP) goals and objectives
  - b. Clearance with authorities involved at the visitation site;
  - c. Arrangements with regard to contact persons, transportation, parental permission, supervision adequate for maintaining safety.
2. Safety provisions for water-related and non water-related activities in natural environments shall adhere to applicable Department of Education procedures and guidelines and site agency's rules and procedures and shall include:
  - a. Assessment of site to identify hazards prior to planned activity;
  - b. Specific warnings and reminders about the identified hazards, when necessary; and
  - c. Adequate supervision to meet the conditions of the activity at the time.

### Planning and Preparation:

1. All water-related activities must be an extension of the standards-driven classroom instructional program or part of a STATE approved activity. Clear objectives must be established which relate to the specific IEP/MP goal and objective being worked on.
2. Staff must conform with all swimming, boating and other water-related activity protocols.
3. Parents/guardians must be informed of the inherent dangers and hazards associated with the activity. Documentation of understanding and agreement by parents/guardians must be received prior to participation and must be kept on file.
4. Parental permission forms should be reviewed prior to the activity. Forms must include student medical information and be carried on the field trip.
5. Staff must conduct an assessment of the site to identify hazards prior to the planned activity and develop appropriate safety instruction for all participants.
6. All staff and students will receive appropriate water safety instruction.
7. Supervision should be adequate and appropriate based on the needs of the student and the IEP/MP.
8. An itinerary shall be filed at the agency and shall include names of all staff/students. Changes in the activity will be immediately reported to the agency.

### On the Day of the Activity/On-Site Checks:

1. Prior to leaving on the activity, students should be monitored for illness, sores, cuts, and other open wounds. Appropriate follow-up measures should be taken.
2. Upon arrival at the site, survey the area quickly to determine if conditions are "normal". Should any unanticipated hazards be identified, an assessment must be made to determine if the activity should continue. The adult staff member(s) will make that determination.
3. Field dangers and hazards, and emergency safety plans will be reviewed with staff at the field site prior to the start of the activity.
4. Staff should spend several minutes with the students observing the area, looking for unanticipated hazards or heavy surf conditions. Point out the possible hazardous areas to the students.
5. Staff will establish and indicate the boundaries of the area to the students.
6. A review of the emergency procedures will be conducted.
7. Applicable safety precautions should be observed while engaged in the activity. Warnings of hazards and reminders of safety procedures should be given throughout

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

the activity as appropriate. One adult should remain on the beach or shoreline to observe the overall activity.

8. A first aid kit, blanket and telephone should be available at the site.
9. It is highly recommended that students protect themselves from the sun by using sunscreen and/or other form of sun protection.

### **Swimming Activity Guidelines:**

In addition to the water-related guidelines indicated, the swimming guidelines listed below will be followed in order to assure safety of participants in swimming situations.

1. The swimming activity must conform to the STATE's water-safety guidelines.
2. Depending on the nature of the swimming activity, at least one certified lifeguard or equivalent person shall be present during the activity.
3. Supervision should be adequate and appropriate based on the needs of the student and the IEP/MP.
4. In addition, at least one staff should be at the site to oversee the entire activity and will not have a student assigned to them. This staff is an "active spotter" and will assist the lifeguard or equivalent person in maintaining safety at the field site.
5. For swimming activities other than "learn to swim", all students will receive instruction and training in the water safety protocol prior to the activity. Successful completion of water-safety instruction and training for all students, including students swimming abilities, will be documented and kept on file. Students should be able to stay afloat in the water for at least one hour. This includes survival float and survival swim.
6. No student will be allowed in the water alone.
7. A water rescue device will be readily available to the staff on shore. Staff will be trained in the deployment of the water rescue device.
8. Warnings of hazards and reminders of safety procedures should be given throughout the activity as appropriate.

### **Boating Activity Guidelines**

In addition to the water-related guidelines, the boating activity guidelines listed below will be followed in order to provide students with a safe boating activity.

1. All boating activities must be an extension of the standards-driven classroom instructional program or part of a STATE approved activity. Clear objectives must be established which relate to the specific IEP/MP goal and objective being worked on.
2. Personnel, knowledgeable in water safety, will be designated as the "safety coordinator" and located on land, boat, or escort vessel to monitor canoe/boat activities.
3. The boat must be seaworthy and equipped with safety equipment, including rescue and firefighting equipment and a personal floatation device (pfd that is age appropriate) for each participant. The vessel must have a current safety check by the U.S. Coast Guard Auxiliary.
4. The boat captain must be a qualified, licensed boat operator (passed boat handling course conducted by the U.S. Coast Guard Auxiliary).
5. The agency and designated activity personnel will have a copy of the boat's flat plan, including list of participants, destination, length of trip, expected departure/arrival times, departure/arrival sites, and alternate plans for inclement weather.
6. Safety orientation must be provided to all participants prior to and during the boating activity as appropriate.
7. Supervision should be adequate and appropriate based on the needs of the student and the IEP/MP. Agency personnel must be able to swim and know safety procedures appropriate for that activity.
8. The vessel's designated passenger limit must not be exceeded.
9. Participants' swimming abilities should be assessed and appropriate safety precautions taken for the boating activity. It is highly recommended that all participants wear

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

personal floatation devices during the boating activity. Non-swimmers MUST wear personal floatation devices.

10. Participants must wear appropriate footwear/attire. They should also protect themselves from the sun by using sunscreen and other sun protection.
11. On the day of the activity, conditions of the site and abilities/preparedness of the participants should be checked prior to the beginning of the activity. Contingency plans should be established and ready for implementation in the event that weather/ocean conditions are inappropriate on the day of the activity.

### **Terrestrial Activities: Hiking**

While terrestrial activities, such as hiking, do not qualify as true water-related activities, there are times when students will come across small streams, ponds, lakes, etc. In these instances during hikes, it is critical that staff be mindful of and observe appropriate water-related safety precautions identified earlier. It is especially important to:

1. Note trail conditions: ease of access to trail, fallen obstacles, overgrown brush and grass, stream crossing, depth of stream, possible areas of fallen rocks, steepness of trail, forks and junctions, and crumbly rocks.
2. Check weather conditions. Recent heavy rains may have caused landslides, mud, and slippery conditions.

### **Other Precautions and Guidelines for Terrestrial Activities**

1. All terrestrial activities must be an extension of the standards-driven classroom instructional program or part of a STATE approved activity. Clear objectives must be established which relate to the specific IEP/MP goal and objective being worked on.
2. Staff will follow routine practices highlighted in the water-related activity guidelines, i.e. surveying the site prior to the activity, obtaining appropriate permissions, filing information with the agency, preparing all students and staff, etc.
3. Supervision should be adequate and appropriate based on the needs of the student and the IEP/MP.
4. Establish rules of conduct appropriate for the group, site, and activity. Discuss procedures to follow in case students "get lost".
5. In addition to first aid kit and related supplies, necessary safety rescue equipment (rope) and communication device (cellular telephone) must be available.
6. Check with appropriate authorities regarding current trail conditions.
7. Plan and write out a "trail plan" and leave it with the agency. Include the following: 1) list of students; 2) time of arrival and approximate departure; 3) travel time to trail head; 4) name of trail; and 5) time on trail.
8. Prepare a checklist of items to bring on the hike: daypack to carry food, water, and other articles; rain gear; sunburn protection; insect repellent; light jacket. Staff should additionally carry: extra shoe laces or cord; water proof matches; gloves; toilet paper; first aid kit; moleskin; compass; permits; pocket knife; and whistle.
9. Discuss appropriate attire for the activity. Students must wear footwear at all times. Slippers are not suitable for hiking activities, and shoes must be required.
10. Take a head count prior to the start of the hike.
11. Select a "point person" (lead hiker) and a "trail sweep" (last hiker).
12. Review emergency procedures in effect during the activity. Indicate the location of safety and first aid equipment.
13. Plan rest stops along the way (approximately five minutes for each hour of hiking).
14. Lift and lower branches that cross the trail instead of pushing them forward.
15. Do not drink water from streams or ponds.
16. Stay on the trail at all times. Avoid going close to the edge of the trail or cliffs. Short cuts may be hazardous, and false trails made by hunters, wild animals and indifferent hikers can cause confusion.
17. If one becomes lost, stay put. A search party will be sent out.

18. Take a final headcount before leaving the site.

### **Emotional Behavioral Assessment** **Psychiatric Diagnostic Evaluation**

#### **Identifying Information**

**Name:** *(last name first, and middle name)*

**Sex:** *(male or female)*

**Date of Birth:** *(e.g., March 2, 1987)*

**Age:** *(e.g., 10 year 9 month)*

**Legal Guardian:**

**School** *(school last attended or currently attending):*

**Grade:**

**Date of Interview:** *(multiple dates if applicable)*

**Date of Report:** *(report completion date)*

**Referral Source:**

**Examiner:** *(name & degree)*

**IDEA/504/SEBD status:**

#### **Reason for Referral**

*Initial comprehensive report, SEBD determination, specific reasons/questions posed by referral source, e.g., disability determination, assessment for intervention in emotional/behavioral crisis, exacerbations of behavioral symptoms; serious and challenging behaviors, such as suicidal behavior, fire-setting, etc.*

#### **Sources of Information**

*Interviews (minimally subject student, parents/guardians or significant others, and school staff/service providers). Other interviews may be helpful: psychiatrist, probation officer, foster parents, DHS worker, FGC care coordinator, others who are involved and knowledgeable concerning the student. Note any other sources of information: past and current medical and legal records, school records, previous mental health evaluation records.*

#### **Chief Complaint or Presenting (Current) Problem**

*Student's subjective complaints (symptoms) & observed findings (signs) of teachers/guardians, main concerns from parent and other referral source(s)*

#### **History of Presenting Problem**

*(Onset, duration, severity/intensity, frequency, quality - include agencies involved in support services, e.g., DOE, DOH, DHS, CPS, OYS, family court.)*

#### **Past Mental Health History**

*Onset of symptoms/signs, diagnoses, past treatment (in- or out-patient settings or residential sites); result of interventions, relapse pattern if occurred and compliance, service intensity, intervention modalities, e.g., CBT, MST, DBT, etc.*

#### **Assessment Tools**

*Required: CAFAS, CALOCUS, and ASEBA data; if not current (within six months) required as part of assessment report data and source. WISC, MMPI, MAYSI-II, BASC2, Sentence Completion and any other tools used. List names of tools. Data will be reported in separate section.*



---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

### Emotional/Behavioral Assessment

### Psychiatric Diagnostic Evaluation

**Name:** *(last, first and middle)*

**Date of Birth:** *(month, day, year)*

### Medical History

*Birth history, contributory pre- and perinatal events/factors such as illnesses and accidents, treatments received (surgical operation and medications), loss of consciousness, congenital deformity, hospitalization, immunization, allergies, hearing and vision problems, chronic and/or familial diseases. And, if physician evaluator, a review of systems.*

### Current Medication

*Current prescription medication(s) (name; dosage, administration time, potential side effects), target behavior/symptoms, student progress (compliance, effectiveness in controlling symptoms, etc., including feedback from parent and school), sites last medication was prescribed (clinic, private physician's office, hospital). List any complementary or alternative remedies used in past or currently.*

### Developmental and Psychosocial History

#### Developmental History

*Birth history such as pre-natal maternal complications or fetal distress, peri- and post-natal history (e.g., difficult labor, jaundice, premature delivery, other maternal and infant complications), birth weight and length, Apgar score, developmental milestones*

#### Family History

*Family origin or parental ethnicity, parental marital status and relationships, relationships among family members, parenting style, parental or family history of mental illness history (genetic predisposition), socioeconomic status, siblings, parental availability to children's needs), description of family dwelling (e.g., 2 bed rooms for 6 family members)*

#### School History

*Schools attended, grade, current educational status, educational testing, preschool program, special education status, repeated grade(s) and when and why, academic performances (strengths and weaknesses), behavioral problems and truancy, suspension, attitude towards school, including school observation (strongly recommended) or formal school data collection including report cards, deficiency notices, disciplinary actions.*

#### Social History

*History of peer relationships, ability and scope of meaningful relationships with others, current peer support, student identified social supports, social and group activities, gang affiliation*

#### Sexual History

*History of sexual activities, gender orientation, history of sexual abuse, birth control knowledge and practice, pregnancy, attitudes towards opposite sex*

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

### Emotional/Behavioral Assessment

#### Psychiatric Diagnostic Evaluation

**Name:** *(last, first and middle)*

**Date of Birth:** *(month, day, year)*

#### Substance Abuse History

*History of substance use/abuse, kinds of abused drugs/substances and age at first usage of each drug, frequency and quantity consumed, alone or with others, drug sales and associated legal problems, family history of substance abuse, attitudes towards substance use/abuse. State whether student has attempted to discontinue drug use and with what effect.*

#### Legal History

*Types of violations/charges, adjudicative dispositions, recidivism, rehabilitative programs attended (success or failure, if failed, why? on probation or parole?), legal guardianship, guardian ad litem, public defender, attitudes towards past illegal activities.*

#### Cultural or Transcultural Issues

*Length of residence in Hawaii, other residence out of state, language spoken by student and family members at home, family cultural factors that may impact on intervention.*

#### Assessment Tool Data:

*Data from each measurement tool noted above, including minimally BASC2, ASEBA, CAFAS, and CALOCUS. Note data source (whether performed by current evaluator or other source of data). Scores and plotted profiles of the ASEBA and CAFAS should be attached to the report and noted in this section as an attachment.*

#### Mental Status Examination

Appearance, attitude, behavioral observations. A general description include presence of any physical deformity or handicap.

Orientation: *(time, place, person).*

Affect and Mood: *engagement pattern, eye contact, affect, depression, recent and past mood swings (depression, euphoria, excitement or irritability, noting frequency and duration of mood swings), and anxiety (including autonomic nervous system signs, e.g., flushing, perspiration, shortness of breath, palpitations, etc.). Psychomotor activity level. Speech pace, note any acceleration or delay.*

Thought content/processes: *fund of knowledge, intelligence, cognitive processes, and memory. Serial subtractions of 7's, presence/absence of any abnormal perception (hallucinations or illusions), cognitive distortions (paranoid thoughts or other delusions), attention span & distractibility, memory impulsive behavior, thought (content and processing), speech (enunciation, age-appropriateness, or unusual content or preoccupations).*

Suicidal or homicidal *ideation or threats; risk assessment.*

School observation (highly recommended) *or data from school.*

#### Physical Examination

*\*\*Strongly recommended when evaluator is physician. Include blood pressure, pulse, height and weight as vital signs. Note obvious serious physical findings. Include a mini-neurological*

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

### Emotional/Behavioral Assessment

### Psychiatric Diagnostic Evaluation

**Name:** *(last, first and middle)*

**Date of Birth:** *(month, day, year)*

*examination minimally noting presence or absence of tics (motor or vocal), tremors, or other abnormalities of movement. Include data from any movement scale used in the evaluation.*

### Student's and Family Strengths

*List student's assets, e.g., good physical health and appearance, any skills (painting, music, sports, readings), being articulate, good in math, etc.)*

*Presence of supports from parent(s), community, and/or significant others (girl- or boy-friend, fiancé), or grandparents, relatives, minister/priest), well-connected and closely following agency support staff.*

### Summary and Formulation

*Reason(s) and rationale to support a diagnosis and to rule out others - based on biological, psychological, social and cultural factors and models. Vulnerabilities and protective factors should be also included if possible.*

### Diagnostic Impressions (DSM-IV)

*All five axes diagnoses should be listed in the order of clinical importance with first diagnosis on Axis I being the focus of current treatment.*

*DO NOT list Rule Out (R/O) diagnoses. If a certain diagnostic entity is suspected but not yet clearly ascertained, include discussion or plans for clarifying or following-up either in formulation or recommendation section. On Axes I and II: if using NOS [not otherwise specified], delineate what features of diagnosis are lacking for a more specific diagnosis.*

### Recommendations

*Describe and address a student's needs. **Recommendations shall not specify a particular service, program, provider or eligibility status.** The IEP/MP Team determines whether a student needs a fully self-contained class, residential placement, at-home instruction, etc. All recommendations shall be supported by empirical research.*

### Provider Information

*Signature*

*Name and degree(s) of the evaluator including the position and name of institution/organization of the evaluator is affiliated (if indicated and appropriate).*

**Emotional/Behavioral Assessment: Annual Update**  
**Psychiatric Medication Evaluation**

**Identifying Information**

**Name:** (last name first, first and middle)  
**Sex:** (male or female)      **Date of Interview:** (multiple dates if applicable)  
**Date of Birth:** (e.g., March 2, 1987)      **Date of Report:** (report completion date)  
**Age:** (e.g., 10 year 9 month)      **Referral Source:**  
**Legal Guardian:**      **Examiner:** (name & degree)  
**School:** (school last attended or      **IDEA/504/SEBD status:**  
currently attending)  
**Grade:**

**Reason for Referral**

*Student requires an annual assessment or psychiatric medication evaluation ,to determine current mental health needs and recommendations, as part of the IDEA/MP requirements, SEBD determination, continued DOH services, or specific reasons/purposes posed by referral source.*

**Sources of Information**

*Interviews (minimally subject student, parents/guardians or significant others, and school staff/service provider). Other interviews ( psychiatrist, probation officer, DHS worker, FGC care coordinator) and past and current medical and legal records, school records, and previous/current emotional/behavioral evaluation records may assist the assessment update.*

**Current Problems and Concerns**

*Student's subjective complaints (symptoms) & observed findings (signs) of teachers/guardians, main concerns from parent and other referral source(s).*

**History of Presenting Problem Since Last Assessment**

*Describe onset, duration, severity/intensity, frequency, quality of any new problems presenting since last assessment. List agencies currently involved in intervention, e.g., DOE, FGC, CPS, OYS, SBBH agencies and other service provider agencies/ organizations.*

**Mental Health History Since Last Assessment**

*Interval history of interventions, changes in treatment approach, acute hospitalizations and other crises.*

**Medical History Since Last Assessment**

*Report changes in health status, diagnoses, medical and surgical treatment of conditions, name of PCP, and additional history obtained since last assessment. For physician examiners, include updated review of systems.*

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

### Emotional/Behavioral Assessment

#### Psychiatric Diagnostic Evaluation

**Name:** *(last, first and middle)*

**Date of Birth:** *(month, day, year)*

#### Assessment Tools

*List names of tools. Required: CAFAS, CALOCUS, and ASEBA data; if not current (within six months) required as part of assessment report data and source. WISC, MMPI, MAYSI-II, BASC2, Sentence Completion and any other tools used. Data will be reported in separate section.*

#### Current Medication

*Current prescription medication(s) (name; dosage, administration time, potential side effects), target behavior/symptoms, student progress (compliance, effectiveness in controlling symptoms, etc., including feedback from parent and school).*

#### Psychosocial History Since Last Assessment

##### Developmental History

*See the attached previous report.*

##### Family History

*Add only changes and additions since the last assessment, e.g. birth or adoption of new sibling, divorce.*

##### School History

*Add only changes and additions since the last assessment. Report school observations or other forms of school data collected.*

##### Social History

*Add only changes and additions since the last assessment.*

##### Sexual History

*Add only changes and additions since the last assessment.*

##### Substance Abuse History

*Add only changes and additions since the last assessment.*

##### Legal History

*Add only changes and additions since the last assessment.*

#### Cultural or Transcultural Issues

*Add only changes and additions since the last assessment.*

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

### Emotional/Behavioral Assessment

### Psychiatric Diagnostic Evaluation

**Name:** (last, first and middle)

**Date of Birth:** (month, day, year)

### Assessment Data:

*Data from each measurement tool noted above, including minimally BASC2, ASEBA, CAFAS, and CALOCUS. Note data source (whether performed by current evaluator or other source of data). Scores and plotted profiles of the ASEBA and CAFAS should be attached to the report and noted in this section as an attachment.*

### Mental Status Examination:

Appearance, attitude, behavioral observations. A general description include presence of any physical deformity or handicap.

Orientation: (time, place, person).

Affect and Mood: engagement pattern, eye contact, affect, depression, recent and past mood swings (depression, euphoria, excitement or irritability, noting frequency and duration of mood swings), and anxiety (including autonomic nervous system signs, e.g., flushing, perspiration, shortness of breath, palpitations, etc.). Psychomotor activity level. Speech pace, note any acceleration or delay.

Thought content/processes: fund of knowledge, intelligence, cognitive processes, and memory. Serial subtractions of 7's, presence/absence of any abnormal perception (hallucinations or illusions), cognitive distortions (paranoid thoughts or other delusions), attention span & distractibility, memory impulsive behavior, thought (content and processing), speech (enunciation, age-appropriateness, or unusual content or preoccupations).

Suicidal or homicidal ideation or threats; risk assessment.

School observation (strongly recommended) or data from school.

### Physical Examination

**\*\*Strongly recommended when evaluator is physician.** Include blood pressure, pulse, height and weight as vital signs. Note obvious serious physical findings. Include a mini-neurological examination minimally noting presence or absence of tics (motor or vocal), tremors, or other abnormalities of movement. Include data from any movement scale used in the evaluation.

### Student's and Family Strengths

Update list of student's assets, e.g., good physical health and appearance, any skills (painting, music, sports, readings), being articulate, good in math, etc.).

Presence of supports from parent(s) and/or significant others (girl- or boy-friend, fiancé or grandparents, relatives, minister/priest), well-connected and closely following agency support staff.

### Summary and Formulation

Reason(s) and rationale to support a diagnosis and to rule out others, to be based on biological, psychological, social and cultural factors and models. Vulnerabilities and protective factors should be also included if possible.

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

### Emotional/Behavioral Assessment

### Psychiatric Diagnostic Evaluation

**Name:** *(last, first and middle)*

**Date of Birth:** *(month, day, year)*

### Diagnostic Impressions (DSM-IV)

*All five axes diagnoses should be listed in the order of clinical importance with first diagnoses being the focus of current interventions.*

*DO NOT list Rule Out (R/O) diagnoses. If a certain diagnostic entity is suspected but not yet clearly ascertained, include discussion or plans for clarifying or following-up either in formulation or recommendation section. On Axes I and II: if using NOS [not otherwise specified] delineate what features of diagnosis are lacking.*

### Recommendations

*Describe and address the student's needs. Recommendations shall not specify a particular service, program, provider or eligibility status. The IEP/MP Team determines whether a student needs a fully self-contained class, residential placement, at-home instruction, etc. All recommendations shall be supported by empirical research.*

### Sources of Additional Information – Most Recent Emotional/Behavioral Reports: *(attach reports)*

- *Admission & Discharge summaries*
- *Intervention summaries including provider monthly summaries*
- *Consultations including pediatric medication assessments*

### Provider Information

*Signature*

*Name and degree(s) of the evaluator*

*The position and name of institution/organization of the evaluator is affiliated (if indicated and appropriate).*

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### PSYCHIATRIC MEDICATION MANAGEMENT PROGRESS NOTE

Student Name:	IDEA/504 Status:	Date of Birth:	Sex M/F
School:	Name of Referral Source:	Student ID (DOE code):	Location of Service:
Frequency of Visits:	Date of Service:	Start time:	End time:

Target Behaviors Addressed with Medication (please check box in front of all that apply):

<input type="checkbox"/>	Aggression	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	Anger (Excessive)	<input type="checkbox"/>	Attention Problems
<input type="checkbox"/>	Enuresis/Encopresis	<input type="checkbox"/>	Hyperactivity	<input type="checkbox"/>	Mania	<input type="checkbox"/>	Impulsive
<input type="checkbox"/>	Phobia/Fears	<input type="checkbox"/>	Self-Injurious Behavior	<input type="checkbox"/>	Psychosis	<input type="checkbox"/>	Poor Self-Control
<input type="checkbox"/>	Sleep Disturbance	<input type="checkbox"/>	Speech/Language Problems	<input type="checkbox"/>	Suicide Risk	<input type="checkbox"/>	Homicide Risk
<input type="checkbox"/>	Traumatic Stress	<input type="checkbox"/>	Oppositional/Noncompliant	<input type="checkbox"/>	Other:	<input type="checkbox"/>	

Date of Parent Feedback Regarding Effects of Medication: \_\_\_\_\_

Date of Feedback from School Staff Regarding Effects of Medication: \_\_\_\_\_

Compliance with Medication: \_\_\_\_\_%

A) Dosage Change or B) Medication Discontinued/Changed (Check One)

A	B	Reason for Action
<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	

Current  
Diagnosis: \_\_\_\_\_

Comments/Progress \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Anticipated Date of Discharge or Transfer: \_\_\_\_\_

\_\_\_\_\_  
Name of Psychiatrist (Print)

\_\_\_\_\_  
Signature of Psychiatrist

\_\_\_\_\_  
Date

Please forward a copy to the parent and home school within 24 hours of the date of service  
Distribution: Parent SSC



## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

ف For Referral  
ف File Only

Timeline Day 1 \_\_\_\_\_ Day 40 \_\_\_\_\_ Day 60 \_\_\_\_\_  
(Dates to be inputted by the school)

Complex/District \_\_\_\_\_ Date of Receipt \_\_\_\_\_

### REFERRAL CHECKLIST FOR EMOTIONAL BEHAVIORAL ASSESSMENTS, PSYCHIATRIC DIAGNOSTIC and MEDICATION EVALUATIONS

Student's Name: \_\_\_\_\_ Student's ID # \_\_\_\_\_

School Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Requestor Name/Ph. \_\_\_\_\_

**I have provided consultation PRIOR to the decision for**

- ☐ A Comprehensive EBA based on Sections A and B below or
- ☐ an EBA –Annual Assessment based on Sections A and B below or
- ☐ Psychiatric Medication Evaluation, based on Sections C and D below
- ☐ Psychiatric Diagnostic Evaluation (for medically or psychiatrically complex needs), based on Sections C and D below

Psychologist/Program Manager \_\_\_\_\_ Date \_\_\_\_\_  
Signature

What is the referral question? \_\_\_\_\_  
\_\_\_\_\_

**For Emotional Behavioral Assessments, please address Sections A and B:**

A. \_\_\_\_\_ All items in “The Standards of Practice for: Considering Emotional Behavioral Assessments” have been addressed affirmatively. (attach)

**B. Justification for the EBA referral is:**

- \_\_\_\_\_ The student is being evaluated for IDEA/504 eligibility and has persistent and serious behavioral problems
- \_\_\_\_\_ The student is IDEA/504 with escalating behavior concerns
- \_\_\_\_\_ Department of Health services are being considered
- \_\_\_\_\_ Concerns may warrant the possible use of medication intervention to augment the Behavior Support Plan
- \_\_\_\_\_ Court Order or other significant justification, such as \_\_\_\_\_

**For a Psychiatric Diagnostic or Psychiatric Medication Evaluation, please address Sections C and D:**

C. \_\_\_\_\_ All items in “The Standards of Practice for: Considering Psychiatric Diagnostic and Medication Evaluations” have been addressed affirmatively. (attach)

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### D. Justification for Psychiatric Evaluation referral is:

- \_\_\_\_\_ The student is being evaluated for IDEA/504 eligibility or is IDEA/504 and has persistent and serious behavioral problems that interfere with learning **AND**
- \_\_\_\_\_ Student's new or current use of psychotropic medications needs to be evaluated **OR**
- \_\_\_\_\_ Concerns may warrant the possible use of medication intervention to augment the Behavior Support Plan and is supported by the Emotional Behavioral Assessment **OR**
- \_\_\_\_\_ The student's needs are **psychiatrically or medically complex** as supported by other assessments **OR**
- \_\_\_\_\_ Court Order or other significant justification, such as \_\_\_\_\_ i \_\_\_\_\_

### E. Referral packet includes the following:

- \_\_\_\_\_ Current Structured Developmental History (SDH) includes addressing hearing, vision, medical concerns Date \_\_\_\_\_
- \_\_\_\_\_ Functional Behavior Assessment Date \_\_\_\_\_ Review Date \_\_\_\_\_
- \_\_\_\_\_ Behavior Support Plan Implementation Date \_\_\_\_\_ Modification Date \_\_\_\_\_
- \_\_\_\_\_ Documentation of consistent follow-up/implementation of recommended interventions from BSP or psychologist justification
- \_\_\_\_\_ BASC-2 baseline/ progress monitoring data
- \_\_\_\_\_ Any student support plans developed prior to FBA
- \_\_\_\_\_ Previous clinical evaluation(s)
- \_\_\_\_\_ English as a Second Language interventions or language assessments, if relevant
- \_\_\_\_\_ Attendance data, concerns and follow-up
- \_\_\_\_\_ Grades for past 4 quarters
- \_\_\_\_\_ Other interventions or assessments, as appropriate (i.e. academic, cognitive, OT, PT, Speech, etc.)
- \_\_\_\_\_ Completed Referral Checklist
- \_\_\_\_\_ Forms 101, 102, consent, PWN
- \_\_\_\_\_ **If DOH-CAMHD referral is a possibility**, Achenbachs, Child Behavior Checklist (blue) and Youth Self-Report ages 11-18 (tan)

### F. \_\_\_\_\_ Copy of the completed & signed Referral Checklist was faxed to the Complex/District designee (to be specified by the district) below

\_\_\_\_\_ Name

\_\_\_\_\_ Fax Number

#### To Be Completed by the Complex/District Designee

##### Assessment is assigned to:

- ☐ **Clinical Psychologist** \_\_\_\_\_
- ☐ **School Psychologist** \_\_\_\_\_
- ☐ **UH-CBT Anxiety Clinic**
- ☐ **\* Procured** \_\_\_\_\_

**\*If service is to be procured, ALL items on the Procurement Procedure form must be completed.**

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

Rev. January 30, 2005

## School-Based Behavioral Health Quarterly Progress Report

School Year: \_\_\_\_\_ Report Period: \_\_\_\_\_ Report Date: \_\_\_\_\_

Student Name:	Student ID:	Grade:
School/Program:	IDEA/504	Frequency of Service:

**Primary Method of Contact/Intervention:** (Select ONE for the quarter.)

<input type="checkbox"/> Consultation	<input type="checkbox"/> Group Session	<input type="checkbox"/> Individual Session	<input type="checkbox"/> Parent Education/Training
<input type="checkbox"/> In-Class Support	<input type="checkbox"/> Observation	<input type="checkbox"/> Crisis Intervention	

**Primary Focus of Intervention:** (Select ONE for the quarter.)

<input type="checkbox"/> Attention/Organization Skills	<input type="checkbox"/> Emotional/Coping
<input type="checkbox"/> Cooperation/Compliance Skills	<input type="checkbox"/> Social Skills

**Service Plan Activities re: Goals/Objectives:** Specify BSP/ IEP/ MP goals and objectives addressed this quarter. In measurable terms, also specify skill development, strategies, interventions for the achievement of those goals.

**Assessment of Progress:** Provide progress monitoring data that supports in measurable terms progress or lack of progress toward each IEP/MP goal/objective; success of interventions, barriers to progress; changing student needs; readiness for transition. Specify anticipated goal completion/transition/exit date. Document BASC-2 findings.

**Progress Indicator for the Quarter:** (check one)

- ☐ Not applicable during this grading period      ☐ No progress made      ☐ Emerging  
☐ Progress Made; Objective not yet met      ☐ Objective met/mastered

**Last Date Service Plan Reviewed** \_\_\_\_\_ **Dates of Contacts with Teacher**

\_\_\_\_\_ **Specify Changes in Service Plan:** (Based on Service Plan Review)

Provider Name:	Phone:	Agency:
Provider Signature:		Distribution: SSC/School Confidential File Parent

Note: This report should be discussed with parent and distributed to the IEP/MP CC before the end of the quarter and if applicable, at the end of each ESY period, or when this IEP/MP service is discontinued.

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## Sentinel Event/ Incident Notification For Department of Education Contracted Providers

Check all that apply:

- ☐ Sentinel events: Occurrences involving serious physical/psychological harm or risk there of \*
- ☐ Provider reports are late or not received      ☐ Services not rendered
- ☐ Non-compliance with Contract/MP/IEP      ☐ System concerns: Interagency disagreements; gaps
- ☐ Other \_\_\_\_\_

Re: Agency/School: \_\_\_\_\_

Describe the incident/concerns:

Describe actions taken by school personnel/provider to resolve the concern:

Describe proposed resolution:

Describe/attach copies of pertinent documentation:

Send Notification to:

- ☐ Parent (\*required for Sentinel Event)      ☐ School Principal      ☐ Agency, if applicable
- ☐ District Educational Specialist(Name) \_\_\_\_\_

Please Indicate:    ☐ FYI, No further action requested      ☐ Further Action Requested

Submitted by:

Print Name

Title

School/Agency

Signature

Date

### To be completed by the District Educational Specialist

Action taken by the DES (if requested):

Send Follow-up Notification to:

- ☐ Referral Originator \_\_\_\_\_  
Date
- ☐ Agency/School, as applicable \_\_\_\_\_  
Specify to Whom Date
- ☐ SPED Administrator (REQUIRED) \_\_\_\_\_  
Date

Completed by:

Print Name

Title

Signature

Date

Form: ISN 82804ps  
Exhibit "A-1", Form F

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

### Incident/Sentinel Event Notification For Department of Education Contracted Providers

#### Instructions

##### **Purpose of Form:**

To be used to notify the appropriate principal, agency and District Educational Specialist when there are occurrences involving serious physical/psychological harm or risk to a student, provider reports are late or not received, provider has not rendered services/gaps in services, or any incident of noncompliance with Service Activities as specified in the IEP/MP(s).

##### **Triggers:**

- |                             |   |
|-----------------------------|---|
| *Harm or risk to student(s) | *Missing reports                                    |
| *Late reports               | *Alleged fraud claims/discrepancy in billing claims |
| *Lack of professionalism    | *Questionable use of best practices application     |
| *Ethics questions           | *Key deliverables not rendered                      |
| *System concerns            |   |

##### **Routing Procedures:**

- 1 Sentinel Events require immediate action and notification to the School Principal to minimize harm or risk to the student, in addition to the submittal of written Incident/Sentinel Notification. An appropriate, individualized plan of action shall be discussed, developed and implemented to ensure student safety.
- 2 Agency/School personnel should try to resolve any complaints/issues with the individual provider, school, or agency. Staff shall keep formal documentation on all actions/communication.
- 3 If personnel cannot resolve the complaints/issues, then the appropriate District Educational Specialist shall be contacted for assistance. The DES shall keep formal documentation on all actions/communications, review, analysis, and follow-up. The DES is also responsible to send a copy of the Incident/Sentinel Notification form to the State Office SPED Administrator for statewide review and analysis.
- 4 If contract complaints/issues cannot be resolved, then the DES shall forward all documentation to the appropriate District Contract Specialist for formal resolution with the school/provider agency. The Contract Specialist will work to resolve complaint/issue.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### Service Verification Form

Provider Name: \_\_\_\_\_ Agency \_\_\_\_\_ Month \_\_\_\_\_

Student Name: \_\_\_\_\_ DOE Student ID # \_\_\_\_\_

Date	School/Site (Specify location)	Type of Service	Start Time/ End Time	* Signature of school personnel/caregiver (start and end time)	Printed name of school personnel/caregiver (start and end time)

Note: Signature verifies that the service was delivered at school/home/community.

Routing Information:

Provider Signature \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

Send copy to Student Service Coordinator via:

☐ Fax receipt

☐ Other \_\_\_\_\_

Date Sent: \_\_\_\_\_

\*\*\* Original document to be kept on file at agency

\* if signature of school personnel/caregiver is different at start and end time two signatures are required

Exhibit "A-1", Form D

Service Verification

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### Student Service Plan (based on current IEP)

Date: \_\_\_\_\_

Student

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Grade: \_\_\_\_\_ School: \_\_\_\_\_

Service: \_\_\_\_\_ Frequency: \_\_\_\_\_ Location: \_\_\_\_\_

Service: \_\_\_\_\_ Frequency: \_\_\_\_\_ Location: \_\_\_\_\_

\* All components to be completed prior to start of service and revision of the service plan

\* All components to be developed in collaboration with DOE personnel.

### Part One

**Background: (Refer to current IEP Present Levels of Performance for strengths, interests and learning style)**

**IEP/MP Goals and Objectives to be addressed (Refer to current IEP Goals/Objectives for condition and mastery)**

IEP/MP Goals and Objectives	Specify Intervention Strategies	Progress Data Monitoring Strategies

Student Service Plan is a DOE requirement for use by contracted service providers

Original to IEP/504 coordinator, copies to SSC and service provider

Exhibit "A-1", Form A

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

Projected length of service to meet the goals stated above: \_\_\_\_\_

### Part Two:

Projected Timeline to Meet Service Goals

T I M E L I N E	Attainment of IEP Goals/Objectives (Specify Date)	Anticipated Transition Period	Anticipated Exit Date

Service Plan Review Date: \_\_\_\_\_ Time: \_\_\_\_\_ Location: \_\_\_\_\_

Next Service Plan Review Date: \_\_\_\_\_ Time: \_\_\_\_\_ Location: \_\_\_\_\_

Participants:

Classroom Teacher: \_\_\_\_\_ Room: \_\_\_\_\_

Service Provider: \_\_\_\_\_ Agency: \_\_\_\_\_

Student Service Plan is a DOE requirement for use by contracted service providers

Original to IEP/504 coordinator, copies to SSC and service provider

Exhibit "A-1", Form A



# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES



## STATE OF HAWAII DEPARTMENT OF EDUCATION

### REQUEST FOR EVALUATION

(For Educational and Related Services from Age 3 to 20)

Name of Child (Last, First, Middle):				
Date of Birth:	Age:	Male ____ Female ____	Grade:	Student's ID number:
Current School or Program:				
Child's Home Address:				
Name of Father or Legal Guardian:		Home Phone:	Message Phone:	Emergency Phone:
Name of Mother or Legal Guardian:		Home Phone:	Message Phone:	Emergency Phone:
Name of Requester:		Relationship to this Child:		
Mailing Address of Requester:		Home Phone:	Business Phone:	Fax Number:
Language Most Often Used by Child:		Language Most Often Used at Home:		

Reason for Request: Please check area(s) of concern and attach any additional information.

☐ Academic      ☐ Behavior      ☐ Fine Motor      ☐ Gross Motor  
☐ Health      ☐ Hearing      ☐ Speech/Language      ☐ Vision  
☐ Other:

Comments:

If parent/guardian requires special accommodations (e.g. language interpretation) to attend/participate in meetings, please describe:

\_\_\_\_\_  
Signature of Requester

\_\_\_\_\_  
Date

**NOTE:** Please submit this request to a public school or Department of Education office.

#### FOR AGENCY USE ONLY:

Date the Department of Education first received this request: \_\_\_\_\_

\_\_\_\_\_  
Initials

ATTACHMENT: Procedural Safeguards Notice (Parent & Student Rights in Special Education and Rights of Parents and Students, Section 504/Chapter 53)

DISTRIBUTION: School, Parent, District

OCISS Form 101 Rev. 03/02  
Request for Evaluation

***SECTION VI – APPENDIX B:***  
**CAMHD DOCUMENTS**

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

### Appendix B CAMHD Documents (As referenced in General Standards)

Document	Name of Document
1.	CASSP Principles
2.	P & P 80.702 – Care Coordination
3.	P & P 80.614 – Referral Acceptance Protocol
4.	EPSDT- Elements of EPSDT Screens and Periodicity Matrix
5.	Referral- Acceptance Form
6.	Independent Psychiatrist Consultation Form
7.	Support for Emotional and Behavioral Development (SEBD) Fact Sheet
8.	SEBD Referral Form
9.	Medication Tracking Form
10.	Medication Transfer Form
11.	Service Provider Monthly Treatment and Progress Summary
12.	Instructions and Codebook for Service Provider Monthly Treatment and Progress Summary
13.	Agency Aggregated Data Form
14.	Agency Quality Indicator Data Reporting Tool
15.	Therapeutic Foster Home Profile Form
16.	P & P 80.805 Sentinel Events
17.	72 Hour Sentinel Event Report
18.	Sentinel Event Code Definitions
19.	Weekly Census Report on Client Status
20.	Waitlisted Youth Form
21.	CAMHD Education Attendance Report
22.	Contracted Agency Quarterly Training Report (Trainer & Trainee Costs)
23.	P & P 80.406 Child Abuse and Neglect Check
24.	P & P 80.308.1 Re-credentialing of Licensed Health Care Professionals
25.	P&P 80.603 Grievances and Grievance Appeals

Note: The Policies and Procedures in this appendix are current as of October 2005. Providers are responsible for following any future revised policies and procedures as they are made available. Please refer to the DOH website for the most current versions [www.hawaii.gov/health/mental-health/camhd/camhd/index.html](http://www.hawaii.gov/health/mental-health/camhd/camhd/index.html):

**STATE OF HAWAII**  
**Child and Adolescent Service System Program (CASSP)**  
**Principles**

1. The system of care will be child and family centered and culturally sensitive, with the needs of the child and family determining the types and mix of services provided.
2. Access will be to a comprehensive array of services that addresses the child's physical, emotional, educational, recreational and developmental needs.
3. Family preservation and strengthening along with the promotion of physical and emotional wellbeing shall be the primary focus of the system of care.
4. Services will be provided within the least restrictive, most natural environment that is appropriate to individual needs.
5. Services which require the removal of a child from his/her home will be considered only when all other options have been exhausted, and services aimed at returning the child to his/her family or other permanent placement are an integral consideration at the time of removal.
6. The system of care will include effective mechanisms to ensure that services are delivered in a coordinated and therapeutic manner, and that each child can move throughout the system in accordance with his/her changing needs, regardless of points of entry.
7. Families or surrogate families will be full participants in all aspects of the planning and delivery of services.
8. As children reach maturity, they will be full participants in all aspects of the planning and delivery of services.
9. Early identification of social, emotional, physical and educational needs will be promoted in order to enhance the likelihood of successful early interventions and lessen the need for more intensive and restrictive services.
10. The rights of children will be protected and effective advocacy efforts for children will be promoted.

---

Developed by the Hawaii Task Force, 1993.

(Adapted from Stroul, Beth A. and Robert M. Friedman, R.M. (1986) *A System of Care for Children & Youth with Severe Emotional Disturbances*. (Revised Edition) Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.)

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT: Care Coordination</b>		<b>Number:</b>	<b>80.702</b>
<b>REFERENCE:</b> Interagency Performance Standards and Practice Guidelines (July 2002); CAMHD Care Coordinator Training Protocol; Health Insurance Portability and Accountability Act of 1996	<b>APPROVED:</b>		
	<i>Signature on File</i>		12/07/04
	Chief		Eff. Date

### PURPOSE

To ensure that timely, appropriate, coordinated, and integrated services are provided to Hawaii youth and families registered with the Child and Adolescent Mental Health Division (CAMHD) of the Department of Health.

### POLICY

1. CAMHD policies and procedures, Interagency Performance Standards and Practice Guidelines (IPSPG), Health Insurance Portability and Accountability Act of 1996 (HIPAA), training protocols and position descriptions shall guide all Family Guidance Center (FGC) Care Coordination activities.
2. All clients registered with CAMHD will have an identified FGC Care Coordinator (CC) within forty-eight (48) hours of receipt of referral at the FGC. [See CAMHD Policy & Procedure (P&P) 80.701, "*Assignment of Family Guidance Center Care Coordinator.*"]
3. The CC serves as the central point of contact for the delivery and coordination of mental health services to youth and families.
4. The CC is responsible for ensuring that needed services, interventions and strategies are identified and delivered in a coordinated manner and in partnership with families. This includes the following activities:
  - A. Ensuring that a sound clinical assessment is conducted that identifies the strengths and needs of the youth and family;
  - B. Convening team meetings to conduct strength-based planning via the Coordinated Service Plan (CSP) process;
  - C. Responsible for the written CSP as discussed and for obtaining the signatures of all participants attesting agreement;
  - D. Implementation of the CSP which includes linkages to other services or programs, referrals to natural community supports, advocacy and coordination with outside agencies and individuals;
  - E. Performing ongoing monitoring and evaluation of the effectiveness of the CSP and services;

#### REVISION HISTORY:

Initial Effective Date: 22 May 2003  
Biannual Review Date:

File Ref:  
A6225

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT: Care Coordination</b>	<b>Number:</b>	<b>80.702</b>
-----------------------------------	----------------	---------------

- F. Through team participation, revising/adapting the plan as needs change;
  - G. Ensuring that the Child and Adolescent Service System Program (CASSP) Principles always guide planning for all services); and
  - H. Upon first contact, and in addition to the prescribed intake procedure (as directed by CAMHD P&P 80.608, "*Client Registration*"), provide the client/parent/legal guardian with a copy of the CAMHD flyer entitled "*Notice of Privacy Practice*" and the CAMHD client/family rights handbook entitled "*Consumer Handbook*." Provide explanation, ensure that the family understands these rights, and obtain parental signature that attests to same.
5. The CC is trained in six core areas in order to perform duties effectively. These areas are:
- A. Engagement Skills
  - B. Intensive Case Management
  - C. Coordinated Service Planning Process
  - D. Mental Health Assessments
  - E. CAMHD Outcome Measurements: CAFAS, CALOCUS and Achenbach
  - F. Evidenced Based Services/Best Practices [Interagency Performance Standards and Practice Guidelines, (IPSPG)]
6. The CC is trained, in accordance with state and federal laws, to adhere to privacy and confidentiality, compliance, the CAMHD Complaints and Grievance process and MedQuest requirements. (See CAMHD P&P 80.603, "*Complaints, Grievances and Appeals*.")
7. Additional training is provided to assist the CC in forming effective working relationships with other child serving agencies, *e.g.* Family Court.
8. Key functions of the CC are to:
- A. Develop collaborative working relationships with other child serving agencies;
  - B. Monitor all services; and
  - C. Participate, with the family, in the development of the Mental Health Treatment Plan (MHTP) and quarterly MHTP reviews. (See CAMHD P&P 80.607, "*Mental Health Treatment Plan*.").
9. The CC receives regular supervision from the Mental Health Supervisor-1 (MHS-1) and presents individual cases for review and guidance to the FGC Clinical Management Team. Cases are presented in an organized manner, using case review tools at each FGC.

### REVISION HISTORY:

Initial Effective Date: 22 May 2003  
Biannual Review Date:

File Ref:  
A6225

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

### POLICY AND PROCEDURE MANUAL

<b>SUBJECT: Care Coordination</b>	<b>Number:</b>	<b>80.702</b>
-----------------------------------	----------------	---------------

10. The CC is provided regular data to evaluate their performance through the CSP Audit Tool, Chart Review Tool, Clinical Supervision Module or Oracle Discoverer.
11. The CC is responsible for notifying his/her Mental Health Supervisor (MHS-1) whenever there is difficulty arranging for the provision of integrated, coordinated services, or if assistance is needed in addressing the treatment needs of the youth/family.
12. In the event of absence due to illness, planned leaves or other reasons the CC will notify the MHS-1 who has the responsibility of assigning an alternate or making themselves available to families as needed. After-hours emergency services are available through a network of CAMHD providers.

### PROCEDURE

1. The CC or his/her MHS-1, through participation at school level Peer Review meetings, may identify youth appropriate for services provided by the FGC. The youth will be registered and assigned to a specific CC in accordance with CAMHD P&P 80.701, "*Assignment of Family Guidance Center Care Coordinator*" and the IPSPG, section IV.
2. The CC shall contact the family/guardian within two (2) workdays to introduce him/herself and to provide the family with contact information and a review of services available through the FGC. Families are also provided phone numbers for any emergency contact that may be needed. Families are informed that after-hours emergency services are provided statewide through a network of CAMHD contracted providers.
3. At the first face-to-face meeting following registration, the CC will inform the client, his/her parent, legal guardian, or third party representative of their rights and responsibilities. The CC will:
  - A. Review and explain the contents of the *Consumer Handbook* and *Notice of Privacy Practice* and, if necessary, offer to obtain an interpreter to give assistance in the explanation of the Handbook and Notice.
  - B. The CC will inform the consumer of CAMHD's array of services, benefits coverage, CAMHD's practices regarding the range of services, issues relative to confidentiality of information, procedural information, service information, specific information about family support and advocacy agencies and accessibility to services as addressed in CAMHD P&P 80.608, "*Client Registration*" and P&P 80.601, "*Consumer Handbook*."
  - C. After the review, obtain the signature of the client's parent, legal guardian, or third party representative on the "*Notice of Privacy Practice*".

### REVISION HISTORY:

Initial Effective Date: 22 May 2003

Biannual Review Date:

File Ref:  
A6225

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT: Care Coordination</b>	<b>Number:</b>	<b>80.702</b>
-----------------------------------	----------------	---------------

- D. Provide client's parent, legal guardian, or third party representatives with a copy of the "Notice of Privacy Practice," and the "Consumer Handbook."
  - E. Place the signed original "Notice of Privacy Practice," in the client's chart.
  - F. Record in client's chart that the Handbook was reviewed with the client, his/her parent, guardian, or third party representative and the date it was given.
- 4. The CC provides the youth/family with information on the array of services available, benefits coverage and informs them of the CSP process which culminates in a coordinated, comprehensive plan that includes a range of formal and informal supports and services which will best meet their child's needs.
  - 5. The CC obtains client's medical insurance information and makes a copy of the insurance card for the client's file. The CC tracks client's insurance and updates information on file as appropriate. Updating of client's insurance will be done once per year for all youths, once per month for Quest insurance, or when changes are reported to the CC.
  - 6. At intake the CC will provide and explain the content of the Family Information Packet that contains information about mental health, special education, system access, family support services and community resources. The CC will inform client/family of the possible referral to a parent partner through a contracted statewide family network organization.
  - 7. The CC arranges to meet with the family and, whenever possible and appropriate, the youth to begin the CSP process. The first meeting includes a strength discovery and assessment of needs and challenges.
  - 8. The CC shall arrange, **within three (3) workdays**, for appropriate mental health services with a contract provider. Contract providers are obligated to provide the services **within time frames outlined in the IPSPG**. The CC is responsible for ensuring that services are provided in a timely manner.
  - 9. The CC, with family participation, identifies all key members of the youth's team and conducts the CSP meeting following CAMHD guidelines within thirty (30) days of registration. CSPs are also updated at least quarterly and whenever there is a change in service, placement or level of care.
  - 10. The CC establishes and maintains collaborative partnerships with other child serving agencies in the system of care and includes them, as appropriate, in planning and service monitoring/evaluation activities. Once a youth has been placed in an appropriate program, residential or otherwise, all lateral arrangements must terminate unless: 1) prior to placement full disclosure is made to the accommodating program of the intent to transfer (non-clinical

### REVISION HISTORY:

Initial Effective Date: 22 May 2003

Biannual Review Date:

File Ref:  
A6225



# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

### POLICY AND PROCEDURE MANUAL

<b>SUBJECT: Care Coordination</b>	<b>Number:</b>	<b>80.702</b>
-----------------------------------	----------------	---------------

discharge) the youth upon availability of a bed in another lateral program; and 2) the accommodating program's consent is obtained.

11. The CC shall continue regular contacts, at least monthly, with the client and family to ensure that they are not in need of other services, to evaluate the effectiveness of services being delivered and to assess their satisfaction with the services provided. Regular contact allows the CC to respond in a timely manner to new or emerging concerns and/or to discontinue services that are no longer needed or deemed ineffective by the team.
12. Should the client, parent, or legal guardian express dissatisfaction with, or a desire to change his/her service provider, the CC will assist them with finding another provider within the CAMHD provider network.
13. The CC will coordinate the sharing of specific, pertinent information with the Primary Care Physician (PCP), other providers and with the client as appropriate. When necessary, signed release/consent forms will be maintained in the client's chart and all required disclosures will be tracked.
14. The CC participates in the FGC clinical management team case reviews to discuss the case and, when necessary, revisit the plan with family and team members to revise or adapt.
15. The CC shall authorize services in accordance with CAMHD P&P 80.621, "*Service Procurement.*"
16. The CC will attend all Individualized Education Program (IEP) meetings for their respective clients in order to coordinate related mental health services deemed necessary by the IEP team.
17. The Care CC will continue to conduct regular (at least monthly) reviews of the services the client is receiving for effectiveness and continued need. The CC will monitor the effectiveness of services through contacts with the youth/family, contacts with the service provider and a review of the provider monthly summaries and quarterly mental health treatment plan reviews in consultation with the IEP team.
18. For youth who also receive outpatient or other services through School Based Behavioral Health (SBBH), the CC will maintain contact with the SBBH staff to monitor the youth progress, emerging needs, ensure clarification of CC's roles and tasks and to provide any coordination needed with the PCP.
19. When a youth is hospitalized and receiving inpatient care, the CC continues to monitor the services and youth progress, coordinates with the family and ensures that the FGC Clinical Director is linked to hospital staff to coordinate psychiatric care while hospitalized and in preparation for discharge. The acute psychiatric hospital unit has been provided with the

#### REVISION HISTORY:

Initial Effective Date: 22 May 2003

Biannual Review Date:

File Ref:  
A6225

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT: Care Coordination</b>	<b>Number:</b>	<b>80.702</b>
-----------------------------------	----------------	---------------

20. telephone numbers of the FGC Clinical Directors for times when a youth is hospitalized for acute psychiatric care while registered at the FGC.
21. The CC will conduct clinical reviews on each client with the supervisor at least monthly, and with the CSP team at least quarterly.
22. The CC will discharge clients when services are deemed no longer necessary, or engagement in services have not occurred within nine (9) months despite concerted attempts to implement services. However, no change in services will occur without convening an IEP meeting for all IDEA youth or a Modification Plan (MP) meeting for 504 youth.
23. The CC is responsible for coordinating with the youth's PCP for all medical related concerns and for including them, when appropriate, in the CSP process. For youth receiving Quest health benefits the CC provides regular information to the PCP on all aspects of treatment planning including: copies of IEPs/MPs, CSPs, MHTPs and mental health assessments, quarterly treatment summaries, information on any medications prescribed by a contracted psychiatrist, information as to any change in placement and discharge summaries.
24. The CC is responsible for implementing all CAMHD initiatives to measure client progress. Components of the evaluation process include quarterly CAFAS, CALOCUS and Achenbachs. The CC uses these tools, in supervision with the MHS-1, to review client progress over time and determine if current services are appropriately matched to the client's acuity level and needs.
25. The CC must document all contacts with the client/family and all care coordination activities in the client's record. Documentation will follow professional standards and will always include the date, time and type of contact. Documentation will include an assessment of the client/family need, current situation, any referrals or other actions to be taken and any follow-up activities. If the CC is documenting a CSP review meeting, specifics as to progress made, effectiveness of strategies, new information and any revisions to the plan will be included. For all CSP meetings documentation will include a sign-in sheet with signatures of all participants. Documentation will be signed with the CC's name, degree and title.

**ATTACHMENTS: NONE**

### REVISION HISTORY:

Initial Effective Date: 22 May 2003

Biannual Review Date:

File Ref:  
A6225

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT: Referral Acceptance Protocol</b>		<b>Number:</b>	<b>80.614</b>
<b>REFERENCE:</b> Hawaii Revised Statutes, and Hawaii Administrative Rules for Chapter 103F	<b>APPROVED:</b>		
	<i>Signature on File</i>		11-15-05
	Chief		Eff. Date

### PURPOSE

To describe the Child and Adolescent Mental Health Division's (CAMHD) process for youth accessing appropriate intensive mental health services from CAMHD contracted providers, hereinafter identified as Providers. This policy establishes the referral acceptance protocol all Providers must follow.

### BACKGROUND

The CAMHD is committed to providing eligible youth and families access to an array of intensive mental health services and service planning delivered by CAMHD staff or Providers in a timely and consistent manner. The CAMHD procures mental health treatment services through the Request for Proposal (RFP) process in accordance with provisions of the Hawaii Revised Statutes, Chapter 103F and its administrative rules. The RFP process results in contractual agreements between the CAMHD and Providers that set forth requirements Providers have agreed to comply with, including referral acceptance requirements.

### DEFINITIONS

*Branch* - CAMHD Family Guidance Center or the Family Court Liaison Branch.

*Coordinated Service Plan (CSP)* - A written design for service that describes the roles and responsibilities of multiple agencies or programs that provide therapeutic or supportive interventions or activities essential to the youth's and family's treatment.

*Mental Health Treatment Team* –A team of involved mental health professionals who are responsible for the development, implementation, review, revision and adjustment of the Mental Health Treatment Plan (MHTP), with input from the Branch Mental Health Care Coordinator (MHCC) and the youth/family via the CSP meeting.

*Mental Health Treatment Plan* –Individualized planning for each youth identifying evidence-based treatment interventions that are the most promising options for delivering positive treatment outcomes for a youth's individual goals and objectives. The Plan includes clear descriptions of specific treatment strategies and services and discharge planning.

*Rejection* – Action taken by a Provider where a youth is not accepted after a referral packet sent by the BRANCH is received and reviewed.

REVISION HISTORY: 04 Feb 03, 19 Mar 03 (80.705), 14 Oct 05 (Consumer Access to CAMHD Svcs)  
Initial Effective Date: 05 May 1997 (80.705)  
Biannual Review Date:

File Ref:  
A7504

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT: Referral Acceptance Protocol</b>	<b>Number:</b>	<b>80.614</b>
--	----------------	---------------

*Ejection* – Action taken by a Provider whereby a consumer is terminated from a placement in the Provider’s treatment program (excluding discharges relating to elopements that last longer than seven days) and the Branch does not agree with the discharge. This includes discharges when the Provider believes the treatment goals have been met but the Branch does not agree.

*Referral Packet* -The packet of information submitted to a Provider by the Branch when a youth is being referred for services. This packet contains, but is not limited to the following: Application; current or most recent Individualized Educational Plan ((IEP) /CSP (as applicable); current Functional Behavioral Assessment (if applicable); DOE diagnostic packet or re-evaluation information (if applicable); and any recent Admission/Discharge Summaries and/or psychiatric/psychological evaluations from previous out-of-home placements as relevant and TB results (if applicable).

*CAMHD Waitlist* – A list where youth are placed when the youth has been accepted for placement but CAMHD contracted bed is not available. This list is provided by the out-of- home Providers using a CAMHD form, “*Waitlisted Youth Report*” which is an attachment to the “*Weekly Census Report on Client Status*.”

*Youth* – Children, youth or young adults with emotional and/or behavioral challenges receiving mental health services from the CAMHD.

### POLICY

1. The CAMHD provides access to the following services for eligible youth through established referral processes:
  - A. Educationally Supportive (ES) services which are available to Individuals with Disabilities Educational Improvement Act (IDEA) eligible children and youth, ages 3-18 (or until 20 years if compensatory education is required). The educationally focused services shall be referred to CAMHD by the youth’s Individualized Education Plan (IEP) team.
  - B. Support for the Emotional and Behavioral Development (SEBD) Health Plan services which are available to Medicaid/QUEST eligible children and youth, ages 3-21 with a mental health diagnosis and significant functional life impairment.
  - C. Mental Health Only (MHO) services which are available to youth, not eligible for ES or SEBD Health Plan services, but deemed to be in need of mental health services. The CAMHD Medical Director shall determine MHO eligibility.
2. CAMHD Branches shall assign a Mental Health Care Coordinator (MHCC) in accordance with *CAMHD Policy & Procedure 80.702, Care Coordination and Policy &*

REVISION HISTORY: 04 Feb 03, 19 Mar 03 (80.705), 14 Oct 05 (Consumer Access to CAMHD Svcs)  
Initial Effective Date: 05 May 1997 (80.705)  
Biannual Review Date:

File Ref:  
A7504

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

### POLICY AND PROCEDURE MANUAL

<b>SUBJECT: Referral Acceptance Protocol</b>	<b>Number:</b>	<b>80.614</b>
--	----------------	---------------

*Procedure 80.701, Assignment of Branch Mental Health Care Coordinator*, to each youth referred to CAMHD to:

- A. Register the youth into Child and Adolescent Mental Health Management Information System (CAMHMIS);
  - B. Facilitate the development of the youth's Coordinated Service Plan (CSP) with the youth, family and all involved parties (DOE, DHS, FC, etc.). The CSP team shall identify the appropriate services and level of care for youth and make appropriate referrals to Providers based on the needs of the youth and in accordance with contractual requirements; and
  - C. Make the appropriate referral to a Provider for services.
3. CAMHD shall inform all Providers of the referral of services process and all other relevant requirements as applicable and ensure that these Providers understand and adhere to the referral acceptance protocol. The CAMHD shall inform the Provider that it reserves the right to take any contractual action if a Provider is unable or unwilling to meet the needs of CAMHD youth appropriately referred to them.

## PROCEDURE

### Referral of Services to Providers:

1. Each Branch will assign an MHCC to each youth accessing services through CAMHD who will be responsible to register the youth into CAMHMIS in accordance with *CAMHD Policy and Procedure 80.608, Client Registration*.
2. The MHCC will be responsible to submit complete referral packets to Providers in accordance with the contractual requirements. All referrals will include an explanation of the purpose of treatment, the goals to be achieved via treatment, anticipated duration of the treatment and the discharge/transition criteria in addition to the required assessment documents.
3. Upon receipt of the referral packet, the Provider will forward, within two (2) business days, the ***“Acceptance of Referral Form”*** (*See Attachment A*) to the Branch confirming acceptance and a date for initiation of services or, if all beds are full, an anticipated admission date. Although a Provider may require interviews with the youth/family as part of their agency intake process, the Provider is still required to return the referral acceptance form to CAMHD within two (2) business days. CAMHD does not require that youth be interviewed.

REVISION HISTORY: 04 Feb 03, 19 Mar 03 (80.705), 14 Oct 05 (Consumer Access to CAMHD Svcs)  
Initial Effective Date: 05 May 1997 (80.705)  
Biannual Review Date:

File Ref:  
A7504

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT: Referral Acceptance Protocol</b>	<b>Number:</b>	<b>80.614</b>
--	----------------	---------------

4. If the *Branch does not receive the "Acceptance of Referral Form"* within two (2) business days, the Branch MHCC will contact the Provider to determine the reason for the delay and to provide any necessary assistance.
5. If the youth is accepted but the program beds are at capacity, the MHCC will ensure that the referred youth is waitlisted by the Provider in the weekly CAMHD *"Waitlisted Youth Report"* (See Attachment B).

#### Provider Rejection of Referral

1. Per their contractual agreement with CAMHD Providers are expected to accept all appropriate CAMHD referrals for contracted services. The MHCC will ensure that Providers follow the referral acceptance protocol that includes a means to justifiably reject a referral should they indicate that a referred youth is not appropriate for their level of care.
2. The Provider must complete the required form to indicate its reasons for the rejection of the referral and submit it to the MHCC. The MHCC will report the rejection to the Branch Clinical Director who will contact the Provider's Clinical Director to discuss the rejection reason(s).
  - A. If, after such discussion, both Clinical Directors agree the level of care is appropriate, the Provider will give the MHCC a date for anticipated initiation of services.
  - B. If, after such discussion, both Clinical Directors are *not* in agreement, the Branch Clinical Director will request that the Provider obtain an independent assessment from a CAMHD approved, Hawaii licensed, qualified child and adolescent psychiatrist, who is independent of CAMHD and the Provider, at the Provider's cost. The Provider must follow CAMHD procedures to determine CAMHD approval of the independent psychiatrist.
  - C. If the independent assessment determines that the level of care is *not* appropriate, the Branch Chief, the Branch Clinical Director and the youth's treatment team will review the independent psychiatrist's recommendations and determine the appropriate level of care and send out a new referral packet to other applicable Providers. The CAMHD will reimburse the Provider for the cost of the assessment.
  - D. If the independent assessment determines that the level of care is appropriate, the Provider will give the Branch a date for anticipated initiation of services. The CAMHD will *not* reimburse the Provider for the cost of the assessment.

REVISION HISTORY: 04 Feb 03, 19 Mar 03 (80.705), 14 Oct 05 (Consumer Access to CAMHD Svcs)  
Initial Effective Date: 05 May 1997 (80.705)  
Biannual Review Date:

File Ref:  
A7504

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

### POLICY AND PROCEDURE MANUAL

<b>SUBJECT: Referral Acceptance Protocol</b>	<b>Number:</b>	<b>80.614</b>
--	----------------	---------------

3. CAMHD CSO must approve the selection of the independent psychiatrist and will describe the guidelines the Provider will follow. The Provider must complete the ***“CAMHD Independent Psychiatrist Consultation Form”*** (See Attachment C) and submit it to the CSO. The CSO will fax its approval or disapproval to the Provider within three (3) business days of the receipt of the form.
4. The MHCC will copy the CSO Resource Management (RM) Supervisor on any rejection letters or rejection indicated on the *“Acceptance of Referral Form”*. The CSO RM Supervisor will forward a copy to the CAMHD Performance Monitoring Section and the Provider Relations Liaison.
5. The CAMHD Performance Monitoring Section will ensure that Providers report the number of rejections and ejections to CAMHD on a designated form. The Branches will verify this information by completing the ***“FGC Data Verification Tracking Tool”***. (See Attachment D)

#### Provider Ejection of Accepted Youth

1. Once referrals are accepted the Provider is expected to keep the youth in its program until such time where discharge is appropriate. Providers *may not* eject youth from their program or terminate services to youth. The MHCC and the Provider are expected to work closely together while the youth is in the Provider’s program. The MHCC will respond to any concerns raised by the Provider by reporting them to the youth’s CSP team, the Branch Clinical Director, the Branch Chief, the CSO Practice Development Section, the Resource Management Section and/or the Provider Relations Liaison Specialist as applicable or needed.
2. In accordance with their contractual agreement with CAMHD, Providers *may not* abruptly terminate services or eject a client from the program. If a Provider seeks to terminate services or eject a youth once in the program:
  - A. The Provider will be required to complete a full internal review that includes a review documented by a CAMHD approved, Hawaii licensed, qualified child and adolescent psychiatrist, who is independent of CAMHD and the Provider at the Provider’s cost. The Provider will be required to report the results of this review to CAMHD and the CSP team prior to any further action being taken.
  - B. CAMHD CSO must approve the selection of the independent psychiatrist and will describe the guidelines the Provider will follow. The Provider must complete the ***“CAMHD Independent Psychiatrist Consultation Form”*** and submit it to the CSO. The CSO will fax its approval or disapproval to the Provider within three (3) business days of the receipt of the form.

REVISION HISTORY: 04 Feb 03, 19 Mar 03 (80.705), 14 Oct 05 (Consumer Access to CAMHD Svcs)  
Initial Effective Date: 05 May 1997 (80.705)  
Biannual Review Date:

File Ref:  
A7504

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

### POLICY AND PROCEDURE MANUAL

<b>SUBJECT: Referral Acceptance Protocol</b>	<b>Number:</b>	<b>80.614</b>
--	----------------	---------------

1. If a Branch receives notification that a Provider wants to eject a youth, the Branch Clinical Director will contact the Provider's Clinical Director to discuss the issue.
2. If, after such discussion, both Clinical Directors agree the level of care continues to be appropriate, the Provider is expected to maintain the consumer in its program.
3. If, after such discussion, both Clinical Directors are *not* in agreement, the Branch Clinical Director will request that the Provider obtain an independent assessment, at the agency's cost, from a CAMHD approved, Hawaii licensed, qualified child and adolescent psychiatrist, who is independent of CAMHD and the Provider. The Provider must follow CAMHD procedures to determine CAMHD approval of the independent psychiatrist.
4. If the independent assessment determines that the level of care is *no* longer appropriate, the Branch will initiate appropriate and timely transition services for the youth. If the level of care is being reduced or care is being terminated, the Provider will be requested to maintain the youth for at least ten (10) days per requirements of the appeal process. The CAMHD will reimburse the Provider for the cost of the assessment.
5. If the independent assessment determines that the level of care continues to be appropriate, the Provider is expected to maintain the consumer in its program. The CAMHD will *not* reimburse the Provider for the cost of the assessment.
6. The MHCC will copy the CSO Resource Management (RM) Supervisor on any ejection letters or ejection indicated on the "*Acceptance of Referral Form*". The CSO RM Supervisor will forward a copy to the CAMHD Performance Monitoring Section and the Provider Relations Liaison.

#### ATTACHMENTS:

- A. Referral Acceptance Form
- B. Waitlisted Youth Form
- C. CAMHD Independent Psychiatrist Consultation Form
- D. FGC Data Verification Tracking Tool

REVISION HISTORY: 04 Feb 03, 19 Mar 03 (80.705), 14 Oct 05 (Consumer Access to CAMHD Svcs)  
Initial Effective Date: 05 May 1997 (80.705)  
Biannual Review Date:

File Ref:  
A7504



### EPSDT ELEMENTS OF EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) SCREENS AND PERIODICITY MATRIX

#### **EPSDT Description**

EPSDT is a federally mandated program for children up to age 21 which emphasizes the importance of prevention through early screening for medical, dental and behavioral health conditions and timely treatment of conditions that are detected.

#### **EPSDT Screen Schedule**

Complete EPSDT screens are conducted at the following ages:

- Infancy: By age 1 month, 2, 4, 6, 9 and 12 months
- Early Childhood: At 15, 18 and 24 months and at 3 and 4 years
- Late Childhood: At 5, 6, 8, 10 and 12 years
- Adolescence and Older: At 14, 16, 18 and 20 years

#### **Elements of EPSDT Screens for children age 3 years and older**

**(Please refer to Hawaii EPSDT Periodic Screening Guidelines on the next page for ages when these various elements are due)**

- a) Initial and Interval Health History
- b) Development/Behavior Assessment
- c) Height
- d) Weight
- e) Blood Pressure Readings
- f) Vision Screening
- g) Hearing/Language Screening
- h) Audiogram
- i) Physical Examination
- j) Immunizations
- k) Tuberculin Skin Testing
- l) Lead Risk Assessment
- m) Hemoglobin/Hematocrit
- n) Other Lab Screens
- o) Oral Exam/Recommended Dental Visit
- p) Fluoride
- q) Health Education and Counseling

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### EPSDT Periodicity Schedule\* (Elements are due at ages indicated below except those shaded)

EPSDT Element	3 yrs	4 yrs	5 yrs	6 yrs	8 yrs	10 yrs	12 yrs	14 yrs	16 yrs	18 yrs	20 yrs
Health History											
Developmental / Behavioral Assessment											
Height											
Weight											
Blood Pressure											
Vision Screening											
Hearing/Language Screening											
Audiogram											
Physical Exam											
Immunization											
TB Risk Assmt and test as indicated											
Lead Risk Assmt											
Hemoglobin / Hematocrit											
Other Lab Screens											
Oral Exam											
Fluoride											

\*For additional information, please refer to the Hawaii Medicaid Provider Manual at <http://www.med-quest.us/PDFs/Provider%20Manual/PMChp0502.pdf>

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## Referral Acceptance Form

**Instructions: Boxes 1 through 12 are to be filled out by the FGC Care Coordinator. (CC)**

[1] Client Name:	[2] Client Registration Number:	[3] LOC Requested
[4] Family Guidance Center (FGC)		[5] FGC Care Coordinator
[6] FGC Phone Number	[7] FGC Fax Number	[8] Date Referral Sent to Agency
[9] Name of Provider Agency		[10] Name of Provider Agency Contact Person
[11] Agency Phone Number		[12] Agency Fax Number

**Instructions: Boxes 13 through 18 are to be filled out by the Provider Agency and returned to the FGC within forty-eight (48) hours of receipt of the referral packet.**

[13] Signature of Contact Person	[14] Printed Name of Contact Person
[15] Date Referral Packet Received	[16] Date Referral Accepted
[17] Anticipated Admit Date <b>OR</b>	[18] Date Waitlisted

PLEASE NOTE: Should your agency decide to reject this referral for any reason, you must complete this form below and return it to the FGC within the required forty-eight (48) hours from the date of receipt of the referral packet. Both the referral form and the justification must be faxed to the attention of the FGC Chief through the above named CC within forty-eight (48) hours of the date of receipt of the referral packet.

All rejections of referrals will be considered to be in breach of contract requirements unless your agency submits this referral form with a written and signed justification from your Clinical Director. The FGC Clinical Director will review the justification for the rejection and will contact your agency Clinical Director for a discussion of the issues. The Care Coordinator will inform your agency Intake Coordinator of the outcome of the discussion and any actions to be taken on the part of the FGC and/or your agency.

REFERRAL REJECTED ☐

JUSTIFICATION ATTACHED ☐

Print Name of Agency Clinical Director

Signature of Agency Clinical Director

Date

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

### INDEPENDENT PSYCHIATRIST CONSULTATION FORM

RFP No. HTH 460-02-02 pg. 2-14 states that a program must agree to maintain a youth after admission but "If a contractor assesses that the agency no longer has the capacity to provide therapeutic programming in that particular residential program...an independent psychiatrist (not the agency psychiatrist) agreed upon by CAMHD, may, at the cost of the agency, conduct an evaluation regarding alternative placement options." Please fax this form to CSO Office 733-9875

Agency Name: \_\_\_\_\_ Date: \_\_\_\_\_

Agency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Name of proposed Independent Psychiatrist: \_\_\_\_\_

Please indicate the qualifications of the psychiatrist as follows:

Yes \_\_\_\_\_ No \_\_\_\_\_ Psychiatrist licensed as MD or DO in the State of Hawaii

Yes \_\_\_\_\_ No \_\_\_\_\_ Current expertise in the Level of Care being disputed (both the level of care disputed and the level of care proposed)

Describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Yes \_\_\_\_\_ No \_\_\_\_\_ Experience and training in child and adolescent psychiatry (prefer psychiatrist boarded in Child Psychiatry - ABPN)

Describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Yes \_\_\_\_\_ No \_\_\_\_\_ Does the psychiatrist proposed work for your agency as employee or as a consultant?

Yes \_\_\_\_\_ No \_\_\_\_\_ Does the psychiatrist proposed work for the Family Guidance Center providing care coordination for youth involved in dispute?

---

CAMHD Clinical Director Review:

Agree \_\_\_\_\_

Do Not Agree: \_\_\_\_\_

Reason: \_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## **Support for Emotional and Behavioral Development (SEBD)**

### **Fact Sheet**

#### **WHAT IS SEBD Program?**

SEBD is an acronym for the Department of Health's (DOH) Child and Adolescent Mental Health Divisions (CAMHD) Support for Emotional and Behavioral Development program.

Formerly known as SED Serious Emotional Disturbance or SEBD Serious Emotional Behavioral Disturbance, CAMHD's SEBD program provides an array of services needed by families to support children and youth with the high-end intensive mental health support.

#### **WHO CAN BE REFERRED?**

Children/youth ages 3 through 20  
AND  
Hawaii Medicaid QUEST or Fee-For-Service (FFS) eligible

#### **WHO CAN MAKE A REFERRAL?**

Parents, legal guardians, DOE, DHS, FC, QUEST Plan, DOH, AG, Private Provider or others who submit a referral to ask for help in getting services.

#### **WHAT ARE THE ELIGIBILITY REQUIREMENTS?**

Child and Adolescent Functional Assessment Scale (CAFAS) score 80 or above  
AND  
Eligible DSM-IV Axis I diagnosis

#### **WHAT ARE THE BENEFITS?**

A child/youth determined to be SEBD eligible is able to receive appropriate individualized CAMHD intensive mental health services.

## **CRITERIA for determination of eligibility for CAMHD Support for Emotional and Behavioral Development (SEBD)**

### **I. CRITERIA**

Children and youth with serious emotional disturbance are individuals who have a Child and Adolescent Functional Assessment Scale (CAFAS) score of 80 or above and currently, or at anytime during the past year, have had a primary DSM-IV Axis I diagnosis.

### **II. EXCLUDED DIAGNOSES**

If the diagnoses listed below are the only DSM-IV diagnoses, the child is ineligible for SEBD services. These diagnoses, however, may and often do co-exist with other DSM-IV diagnoses, which make the youth eligible for SEBD services.

#### **Mental Retardation**

- 317 Mild Mental Retardation
- 318.0 Moderate Mental Retardation
- 318.1 Severe Mental Retardation
- 318.2 Profound Mental Retardation
- 319 Mental Retardation, Severity Unspecified

#### **Learning Disorders**

- 315.0 Reading Disorder
- 315.1 Mathematics Disorder
- 315.2 Disorder of Written Expression
- 315.9 Learning Disorder NOS

#### **Motor Skills Disorder**

- 315.3 Developmental Coordination Disorder

#### **Communication Disorders**

- 315.31 Expressive Language Disorder
- 315.32 Mixed Receptive-Expressive Language Disorder
- 315.39 Phonological Disorder
- 307.0 Stuttering
- 307.9 Communication Disorder NOS

#### **Pervasive Developmental Disorders**

- 299.0 Autistic Disorder
- 299.80 Rett's Disorder
- 299.10 Childhood Disintegrative Disorder
- 299.80 Asperger's Disorder
- 299.80 Pervasive Developmental Disorder NOS

#### **Substance Abuse Disorders**


#### **Mental Disorders Due to a General Medical Condition**

### III. PROVISIONALLY QUALIFIED

Children and youth provisionally qualified as SEBD are defined as those:

- Who have a substance abuse condition and are suspected to suffer from a qualifying condition due to their symptoms and functional limitations. These children and youth have ongoing and recent substance abuse, which prevents the clinician from making a definitive qualifying diagnosis.
- Cases in which the impairment is profound and short-term.
- Whose degrees of impairment falls mainly within the emotional/self-harm domains that show strong evidence of serious disturbance.

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	State of Hawaii Department of Health Child And Adolescent Mental Health Division <b>SEBD REFERRAL FORM</b> <b>SUPPORT FOR EMOTIONAL and BEHAVIORAL DEVELOPMENT (SEBD)</b>																															
<b>INSTRUCTION:</b> Complete Part 1 and fax it to 733-8375, with a cover page, or to the nearest CAMHD Family Guidance Center. For questions, call (808) 733-9815.																																
<b>PART 1. (TO BE COMPLETED BY THE REFERRAL SOURCE)</b> <span style="float: right;"><b>Date:</b> _____</span>																																
<b>CLIENT INFORMATION</b>																																
Client Name: <span style="float: right;">Gender: _____</span> <div style="display: flex; justify-content: space-between; width: 80%; margin: 0 auto;"> <span>Last</span> <span>First</span> <span>MI</span> </div>																																
DOB: _____ SSN: - - School attending: _____																																
QUEST/Medicaid FFS ID: _____ Med-QUEST Eligibility Date: _____ Health Plan Name: _____																																
Parent/Legal Guardian: _____ Phone No.: _____																																
Mailing Address: _____																																
Youth's address (if different from Parent/Guardian): _____ How long _____																																
<i>I hereby consent to the evaluation of my child for the purpose of determining SEBD eligibility and agree that CAMHD may obtain information about my child with the understanding that it cannot be disclosed to others without my further approval, unless permitted by Federal or State law. I also understand that this consent expires in one year.</i>																																
Parent/Legal Guardian Signature: _____ Date: ____/____/____																																
<b>REFERRAL SOURCE INFORMATION</b>																																
Referral Submission Date: _____ Referral Type: <input type="checkbox"/> Initial <input type="checkbox"/> Reconsideration																																
Referring Agency/Organization & Unit: _____																																
Referring Person's Name/Phone/Fax: _____																																
<i>I hereby certify that the information I have provided is accurate to best of my knowledge and I recommend the above client for SEBD status consideration.</i>																																
Referring Person's Signature: _____ Date: ____/____/____																																
If DHS has custody of youth, is it permanent custody <input type="checkbox"/> Yes <input type="checkbox"/> No																																
<b>DSM-IV DX CODE</b>	Primary _____ Secondary _____																															
Axis I	_____																															
Axis II	_____																															
Axis III	_____																															
Axis IV	_____																															
Axis V	_____																															
Diagnosis Date: _____ Diagnosed By: _____																																
<b>CAFAS (CHILD AND ADOLESCENT FUNCTIONAL ASSESSMENT SCALE)</b>	<b>SUPPORTING DOCUMENTS</b> (List and attach assessments and plans to support diagnoses. If insufficient space, use separate sheet.)																															
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Dimensions</th> <th style="text-align: left;">Scores</th> </tr> </thead> <tbody> <tr><td>School/Work Role Performance</td><td>_____</td></tr> <tr><td>Home Role Performance</td><td>_____</td></tr> <tr><td>Community Role Performance</td><td>_____</td></tr> <tr><td>Behavior Toward Others</td><td>_____</td></tr> <tr><td>Moods/Emotions</td><td>_____</td></tr> <tr><td>Self-Harmful Behavior</td><td>_____</td></tr> <tr><td>Substance Abuse</td><td>_____</td></tr> <tr><td>Thinking</td><td>_____</td></tr> <tr><td>8-SCALE TOTAL SCORE</td><td>_____</td></tr> <tr><td>Date CAFAS Administered:</td><td>_____</td></tr> </tbody> </table>	Dimensions	Scores	School/Work Role Performance	_____	Home Role Performance	_____	Community Role Performance	_____	Behavior Toward Others	_____	Moods/Emotions	_____	Self-Harmful Behavior	_____	Substance Abuse	_____	Thinking	_____	8-SCALE TOTAL SCORE	_____	Date CAFAS Administered:	_____	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Assessments</th> </tr> </thead> <tbody> <tr><td>_____</td></tr> <tr><td>_____</td></tr> <tr><td>Treatment/ Service Plans</td></tr> <tr><td>_____</td></tr> <tr><td>_____</td></tr> <tr><td>Others</td></tr> <tr><td>_____</td></tr> <tr><td>_____</td></tr> </tbody> </table>	Assessments	_____	_____	Treatment/ Service Plans	_____	_____	Others	_____	_____
Dimensions	Scores																															
School/Work Role Performance	_____																															
Home Role Performance	_____																															
Community Role Performance	_____																															
Behavior Toward Others	_____																															
Moods/Emotions	_____																															
Self-Harmful Behavior	_____																															
Substance Abuse	_____																															
Thinking	_____																															
8-SCALE TOTAL SCORE	_____																															
Date CAFAS Administered:	_____																															
Assessments																																
_____																																
_____																																
Treatment/ Service Plans																																
_____																																
_____																																
Others																																
_____																																
_____																																



# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

Client Name: \_\_\_\_\_

## PSYCHOSOCIAL INTERVENTION STRATEGIES UTILIZED

(Check all that apply. If insufficient space or for other approaches, continue on separate sheet.)

<b>Individual Therapy</b> <input type="checkbox"/> Individual Therapy <input type="checkbox"/> Individual Interpersonal Therapy <input type="checkbox"/> Biofeedback Therapy <input type="checkbox"/> Cognitive Behavioral Therapy <input type="checkbox"/> Exposure Therapy	<b>Group Therapy</b> <input type="checkbox"/> Group Therapy <input type="checkbox"/> Group Psychoeducational Therapy	<b>Family Therapy</b> <input type="checkbox"/> Family Therapy <input type="checkbox"/> Parent Psychoeducational Therapy
---	--	---

## HISTORY OF HOSPITALIZATION (Start with current hospitalization. If insufficient space, continue on separate sheet.)

Facility Name	Location	Admit Date	Discharge Date	Diagnoses

## HISTORY OF MEDICATION TRIALS (Start with current medication. If insufficient space, continue on separate sheet.)

Medication Name	Strength	Freq	Start Date	End Date	Managing Physician	If Discontinued, Specify Reason

## HISTORY OF OUTPATIENT TREATMENT (Start with current. If insufficient space, continue on separate sheet.)

Therapist/ Provider	Diagnoses	Start Date	End Date

## PART 2. (TO BE COMPLETED BY THE FAMILY GUIDANCE CENTER)

FGC/Office: _____	CR#: _____
Current Registration Date: _____	
CAMHD BHP enrollment: <input type="checkbox"/> yes <input type="checkbox"/> no	
<i>I hereby certify that I have reviewed this referral and reviewed the recommendation for the above client's SEBD status and recommend SEBD</i> <input type="checkbox"/> Yes <input type="checkbox"/> Provisional <input type="checkbox"/> No.	
Clinical Director Signature: _____	Date:        /        /

## PART 3. (TO BE COMPLETED BY THE SEBD REVIEW PANEL)

Determination Date: _____	Next Review Date: _____
SEBD Determination: <input type="checkbox"/> Yes <input type="checkbox"/> Provisional <input type="checkbox"/> No	SEBD Begin Date: _____
Comments: <input type="checkbox"/> Criteria Met <input type="checkbox"/> Criteria Not Met <input type="checkbox"/> Other (see below)	
Medical Director Signature: _____	

---

**INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES**

---

**STATE OF HAWAII  
CHILD & ADOLESCENT MENTAL HEALTH DIVISION  
MEDICATION TRACKING FORM**

**Treating Physician: Please Complete at each Patient Visit**  
***CAMHD Provider Agency: Please sign at the bottom indicating receipt of form***

**Current Medications Prescribed**

Please indicate all current medications. Please \* new medications Rx'd at this visit

<b><i>Medication</i></b>	<b>Dosage</b>	<b>Time/Fx</b>	<b>Possible Side Effects/ Precautions</b>

**DISCONTINUED MEDICATIONS**

Please indicate medications discontinued at this visit and the reason for discontinuing

<b>Medication Discontinued</b>	<b>Reason for Discontinuing</b>

**Medication Management Evaluation**

<b><i>Medication</i></b>	<b>% Compliance*</b> Excellent 91%-100% Good 71%-90% Fair 51%-70% Poor 0-50%	<b><i>Therapeutic Goal/s of Medication</i></b>	<b>% Goal Achieved</b> Excellent 91%-100% Good 71%-90% Fair 51%-70% Poor 0-50%

\* % compliance based on frequency of refills and/or patient report

## **INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES**

---

**Comments:** \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by CAMHD Agency: RN Signature \_\_\_\_\_ Date: \_\_\_\_\_

---

**INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES**

---

**STATE OF HAWAII  
CHILD & ADOLESCENT MENTAL HEALTH DIVISION  
MEDICATIONS TRANSFER FORM**

Please use this form when a youth is being transferred from an agency with Rx Meds

**YOUTH NAME:** \_\_\_\_\_ **DATE OF TRANSFER:** \_\_\_\_\_

**DOB:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **CR#:** \_\_\_\_\_

<i><b>MEDICATION</b></i>	<i><b>LAST GIVEN (Date &amp; Time)</b></i>	<b>Number / Amount of Med being transferred</b>

**Youth's: Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ **B/P** \_\_\_\_\_ **P** \_\_\_\_\_

**Comments:** \_\_\_\_\_

**Releasing Agency:**

Staff Signature \_\_\_\_\_ Name Printed \_\_\_\_\_ Date \_\_\_\_\_

Physician or RN Signature \_\_\_\_\_ Name Printed \_\_\_\_\_ Date \_\_\_\_\_

**Receiving Agency:**

Signature \_\_\_\_\_ Name Printed \_\_\_\_\_ Date \_\_\_\_\_

Physician or RN Signature \_\_\_\_\_ Name Printed \_\_\_\_\_ Date \_\_\_\_\_

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## SERVICE PROVIDER MONTHLY TREATMENT & PROGRESS SUMMARY Child and Adolescent Mental Health Division (CAMHD)

**Instructions:** Please complete and electronically submit this form to CAMHD by the 5<sup>th</sup> working day of each month (summarizing the time period of 1<sup>st</sup> to the last day of the previous month). The information will be used in service review, monitoring, planning and coordination in accordance with CAMHD policies and standards. Mahalo!

Client Name:	CR #:	DOB:
Month/Year of Services:	Primary Diagnosis:	Eligibility Status:
Level of Care (one per form):		

**Service Format (circle all that apply):**

Individual      Group      Parent      Family      Teacher      Other: \_\_\_\_\_

**Service Setting (circle all that apply):**

Home      School      Community      Out of Home      Clinic/Office      Other: \_\_\_\_\_

Service Dates:																
----------------	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

**Targets Addressed This Month (number up to 10):**

Activity Involvement	Contentment, Enjoyment, Happiness	Learning Disorder, Underachievement	Phobia/Fears	Sleep Disturbance
Academic Achievement	Depressed Mood	Low Self-Esteem	Positive Thinking/Attitude	Social Skills
Aggression	Eating, Feeding Problems	Mania	Psychosis	Speech and Language Problems
Anger	Empathy	Medical Regimen Adherence	Runaway	Substance Use
Anxiety	Enuresis, Encopresis	Oppositional/Non-Compliant Behavior	School Involvement	Suicidality
Assertiveness	Fire Setting	Peer Involvement	School Refusal/Truancy	Traumatic Stress
Attention Problems	Gender Identity Problems	Peer/Sibling Conflict	Self-Control	Treatment Engagement
Avoidance	Grief	Personal Hygiene	Self-Injurious Behavior	Willful Misconduct, Delinquency
Cognitive-Intellectual Functioning	Health Management	Positive Family Functioning	Sexual Misconduct	Other:
Community Involvement	Hyperactivity	Positive Peer Interaction	Shyness	Other:

**Progress Ratings This Month (check appropriate rating for any target numbers endorsed above):**

#	Deterioration < 0%	No Significant Changes 0%-10%	Minimal Improvement 11%-30%	Some Improvement 31%-50%	Moderate Improvement 51%-70%	Significant Improvement 71%-90%	Complete Improvement 91%-100%	Date (If Complete)
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

CR # \_\_\_\_\_ (please repeat the number here)

## Intervention Strategies Used This Month (check all that apply):

Activity Scheduling	Eye Movement, Tapping	Marital Therapy	Play Therapy	Stimulus or Antecedent Control
Assertiveness Training	Family Engagement	Medication/Pharmacotherapy	Problem Solving	Supportive Listening
Biofeedback, Neurofeedback	Family Therapy	Mentoring	Psychoeducation, Child	Tangible Rewards
Catharsis	Free Association	Milieu Therapy	Psychoeducation, Parent	Therapist Praise/Rewards
Cognitive/Coping	Functional Analysis	Mindfulness	Relationship or Rapport Building	Thought Field Therapy
Commands/ Limit Setting	Guided Imagery	Modeling	Relaxation	Time Out
Communication Skills	Hypnosis	Motivational Interviewing	Response Cost	Twelve-step Programming
Crisis Management	Ignoring or DRO	Natural and Logical Consequences	Response Prevention	Other:
Directed Play	Insight Building	Parent Coping	Self-Monitoring	Other:
Educational Support	Interpretation	Parent-Monitoring	Self-Reward/ Self-Praise	Other:
Emotional Processing	Line of Sight Supervision	Parent Praise	Skill Building	
Exposure	Maintenance or Relapse Prevention	Peer Modeling or Pairing	Social Skills Training	

Psychiatric Medications (List All)	Total Daily Dose	Dose Schedule	Check if Change	Description of Change
_____	_____	_____	<input type="checkbox"/>	_____
_____	_____	_____	<input type="checkbox"/>	_____
_____	_____	_____	<input type="checkbox"/>	_____
_____	_____	_____	<input type="checkbox"/>	_____
_____	_____	_____	<input type="checkbox"/>	_____

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

CR # \_\_\_\_\_ (please repeat the number here)

Projected Discharge Date: \_\_\_\_\_ ☐ Check if Discharged During Current Month

**IF YOUTH WAS DISCHARGED THIS MONTH, PLEASE COMPLETE ITEMS A & B:**

**A. Discharge Living Situation (check one):**

☐ Home ☐ Foster Home ☐ Group Care ☐ Residential Treatment  
☐ Institution/Hospital ☐ Jail/Correctional Facility ☐ Homeless/Shelter ☐ Other: \_\_\_\_\_

**B. Reason(s) for Discharge (check all that apply):**

☐ Success/Goals Met ☐ Insufficient Progress ☐ Family Relocation  
☐ Runaway/Elopement ☐ Refuse/Withdraw ☐ Eligibility Change ☐ Other: \_\_\_\_\_

**Outcome Measures:** Optional. If you have any of the following data, please report the most recent scores:

CAFAS (8 Scales): (1-School: ) (2-Home: ) (3-Community: ) (4-Behavior Toward Others: )	Date:
(5-Moods/Emotions: ) (6-Self-Harm: ) (7-Substance: ) (8-Thinking: ) (Total: )	
CASII/CALOCUS (Total): CASII/CALOCUS (Level of Care):	Date:
CBCL (Total Problems T): CBCL (Internalizing T): CBCL (Externalizing T):	Date:
YSR (Total Problems T): YSR (Internalizing T): YSR (Externalizing T):	Date:
TRF (Total Problems T): TRF (Internalizing T): TRF (Externalizing T):	Date:
Arrested During Month? (Y/N): School attendance (% of days):	

**Comments/Suggestions** *(attach additional sheets if necessary):*

Provider Agency & Island: _____	Clinician Name and ID#: _____
Provider Supervisor Signature: _____	Clinician Signature: _____
Submitted to CAMHD (date): _____	Care Coordinator: _____

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

### DOH Child and Adolescent Mental Health Division Instructions and Codebook for Service Provider Monthly Treatment and Progress Summary

---

*The instructions and codebook are to be used in conjunction with the CAMHD Service Provider Monthly Treatment and Progress Summary form. This codebook defines the numerous terms and possible responses necessary to accurately complete the form. For questions regarding these definitions or the use of the Monthly Treatment and Progress Summary, please contact the Clinical Services Office at 733-9349.*

#### Instructions

Please complete and electronically submit to CAMHD the Monthly Treatment and Progress Summary by the 5<sup>th</sup> working day of the month. The summary should pertain to the previous month's services. This form should be completed by the clinician who is most familiar with the current status of the youth and family and with the services provided during the month. When necessary, the responding clinician should gather information from other provider team members to assure the most accurate description possible. Once completed by the clinician, the form should be reviewed and signed by a qualified supervisor.

At the top section, please write the Client Name, CR Number, Date of Birth (DOB), Home School, School Complex, Eligibility Status [i.e., Educationally Supportive (IDEA), Support for Emotional and Behavioral Development (SEBD), Mental Health Only], Primary Diagnosis, Level of Care, and Month/Year of Services. The Month/Year of Services refers to the month in which the service was provided, not the date the Monthly Provider Summary was completed. For example, if the report is submitted in the first week of June, the Month/Year of Services would read "May," because the services were delivered in May. For youth receiving more than one level of care during the month, please complete a separate form for each.

Under Service Format, please indicate whether services were delivered in the following manner (more than one format can be selected):

- Individual –Working with youth directly
- Group –Working with youth along with other youths receiving services
- Parent –Working directly with parents or caretakers, with youth not present
- Family – Working with parents or caretakers and youth together. Can include other family members
- Teacher – Working with a teacher directly
- Other – Another format not specified above; please write description

Under Service Setting, please note whether services were delivered in the following locations (more than one setting can be selected):

- Home –Working with youth or family members in the youth's home
- School –Working with youth or professionals in the youth's educational setting, other than in the context of an IEP/MP meeting

Revised 11-15-2005



---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

Community – Working with youth or others in the youth’s community/neighborhood  
Out of Home – Working with the youth or family in a residential facility  
Clinic/Office – Working with the youth or family in a clinical office  
Other – Another setting not specified above; please write description

For Service Dates, please provide the dates for each service provided during that month. If additional space is required, please continue writing dates in the area below the boxes provided. If the service was provided out of home (i.e., continuously), please provide start and end dates for that month’s services and put the word “to” in between in one of the boxes.

### Targets

Targets are the strengths and needs being addressed as part of the mental health services for that youth.

When completing the Targets Addressed This Month, please put numbers (1, 2, 3...) rather than checkmarks (X, ✓) to the left of each target addressed. This is so that progress ratings in the next section can be attached to each target. For example, if “Academic Achievement” was targeted, place a “1” in the box to the left of that target on the form. Numbers do not need to reflect any particular order. If more than 10 targets were addressed during the month, please provide only those you feel are the 10 most important. If a target was addressed for which there is no option, please number the “other” box, and write in the target.

The list of treatment targets is intended to provide a summary of strengths and needs that are commonly targeted for change during mental health service provision. These problem areas are NOT diagnostic descriptions and the primary targets for treatment may change over time for a particular youth. For example, when treating a youth with an eating disorder, treatment may target eating/feeding behavior at one point, but target medical regimen adherence or positive family functioning on other occasions. These treatment targets are for progress summary purposes and should NOT replace the detailed specification of goals and objectives as part of the treatment planning process.

### Definitions of Targets

1. **Academic Achievement** – Issues related to general level or quality of achievement in an educational or academic context. This commonly includes performance in coursework, and excludes cognitive-intellectual ability/capacity issues (#9) and specific challenges in learning or achievement (#21)
2. **Activity Involvement** – Issues related to general engagement and participation in activities. Only code here those activities that are not better described by the particular activity classes of school involvement (#35), peer involvement (#26), or community involvement (#10).
3. **Aggression** – Verbal and/or physical aggression, or threat thereof, that results in intimidation, physical harm, or property destruction.
4. **Anger** – Emotional experience or expression of agitation or destructiveness directed at a particular object or individual. Common physical feelings include accelerated heartbeat, muscle tension, quicker breathing, and feeling hot.

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

5. **Anxiety** – A general uneasiness that can be characterized by irrational fears, panic, tension, physical symptoms, excessive anxiety, worry, or fear.
6. **Assertiveness** – The skills or effectiveness of clearly communicating one's wishes. For example, the effectiveness with which a child refuses unreasonable requests from others, expresses his/her rights in a non-aggressive manner, and/or negotiates to get what s/he wants in their relationships with others.
7. **Attention Problems** – Described by short attention span, difficulty sustaining attention on a consistent basis, and susceptible to distraction by extraneous stimuli.
8. **Avoidance** – Behaviors aimed at escaping or preventing exposure to a particular situation or stimulus.
9. **Cognitive-Intellectual Functioning** – Issues related to cognitive-intellectual ability/capacity and use of those abilities for positive adaptation to the environment. This includes efforts to increase IQ, memory capacity, or abstract problem-solving ability.
10. **Community Involvement** – Issues related to the amount of involvement in specific community activities within the child's day.
11. **Contentment/Enjoyment/Happiness** – Refers to issues involving the experience and expression of satisfaction, joy, pleasure, and optimism for the future.
12. **Depressed Mood** – Behaviors that can be described as persistent sadness, anxiety, or "empty" mood, feelings of hopelessness, guilt, worthlessness, helplessness, decreased energy, fatigue, etc.
13. **Eating/Feeding Problems** – Knowledge or behaviors involved with the ingestion or consumption of food. May include nutritional awareness, food choice, feeding mechanics (e.g., swallowing, gagging, etc.), and social factors relating with eating situations.
14. **Empathy** – Identifications with and understanding of another person's situation, feelings, and motives.
15. **Enuresis/Encopresis** – Enuresis refers to the repeated pattern of voluntarily or involuntarily passing urine at inappropriate places during the day or at night in bed or clothes. Encopresis refers to a repeated pattern of voluntarily or involuntarily passing feces at inappropriate places.
16. **Fire Setting** – Intentionally igniting fires.
17. **Gender Identity Problems** – Issues related with a youth's self-concept or self-understanding involving gender roles and social behaviors in relation to their biological sex. This does not address self-concept issues involving sexual orientation, which would be coded as "other."
18. **Grief** – Feelings associated with a loss of contact with a significant person in the youth's environment (e.g., parent, guardian, friend, etc.).
19. **Health management** – issues related to the improvement or management of one's health, inclusive of both physical illness and fitness. In addition to dealing with the general development of health-oriented behavior and management of health conditions, this target can also focus on exercise or lack of exercise.
20. **Hyperactivity** – Can be described by fidgeting, squirming in seat, inability to remain seated, talking excessively, difficulty engaging in leisure activities quietly, etc.
21. **Learning Disorder, Underachievement** – Refers to specific challenges with learning or educational performance that are not better accounted for by cognitive-intellectual functioning (#9) or general academic achievement (#1).

22. **Low Self-Esteem** – An inability to identify or accept his/her positive traits or talents, and accept compliments. Verbalization of self-disparaging remarks and viewing him or herself in a negative manner.
23. **Mania** – An inflated self-perception that can be manifested by loud, overly friendly social style that oversteps social boundaries, and high energy and restlessness with a reduced need for sleep.
24. **Medical Regimen Adherence** – Knowledge, attitudes, and behaviors related to regular implementation procedures prescribed by a health care professional. Commonly include lifestyle behaviors (e.g., exercise, nutrition), taking medication, or self-administration of routine assessments (e.g., taking blood samples in a diabetic regimen).
25. **Oppositional/Non-Compliant Behavior** – Behaviors that can be described as refusal to follow adult requests or demands or established rules and procedures (e.g., classroom rules, school rules, etc.).
26. **Peer Involvement** – A greater involvement in activities with peers. Activities could range from academic tasks to recreational activities while involvement could range from working next to a peer to initiating an activity with a peer.
27. **Peer/Sibling Conflict** – Peer and/or sibling relationships that are characterized by fighting, bullying, defiance, revenge, taunting, incessant teasing and other inappropriate behaviors.
28. **Phobia/Fears** – Irrational dread, fear, and avoidance of an object, situation, or activity.
29. **Personal Hygiene** – Challenges related to self-care and grooming.
30. **Positive Family Functioning** – Issues related with healthy communication, problem-solving, shared pleasurable activities, physical and emotional support, etc. in the context of an interaction among multiple persons in a family relation, broadly defined.
31. **Positive Peer Interaction** – Social interaction and communication with peers that are pro-social and appropriate. This differs from peer involvement (#26) in that it focuses on interactional behavior, styles, and intentions, whereas peer involvement targets actual engagement in activities with peers regardless of interactional processes.
32. **Positive Thinking/Attitude** – This target involves clear, healthy, or optimistic thinking, and involves the absence of distortions or cognitive bias that might lead to maladaptive behavior.
33. **Psychosis** – Issues related to atypical thought content (delusions of grandeur, persecution, reference, influence, control, somatic sensations), and/or auditory or visual hallucinations.
34. **Runaway** – Running away from home or current residential placement for a day or more.
35. **School Involvement** – Detailed description of amount of involvement in specific school activities within the child's scheduled school day.
36. **School Refusal/Truancy** – Reluctance or refusal to attend school without adult permission for the absence. May be associated with school phobia or fear manifested by frequent somatic complaints associated with attending school or in anticipation of school attendance, or willful avoidance of school in the interest of pursuing other activities.
37. **Self-Injurious Behavior** – Acts of harm, violence, or aggression directed at oneself.
38. **Self-Management/Self-Control** – Issues related to management, regulation, and monitoring of one's own behavior.
39. **Sexual Misconduct** – Issues related with sexual conduct that is defined as inappropriate by the youth's social environment or that includes intrusion upon or violation of the rights of others.

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

40. **Shyness** – Social isolation and/or excessive involvement in isolated activities. Extremely limited or no close friendships outside the immediate family members. Excessive shrinking or avoidance of contact with unfamiliar people.
41. **Sleep Disturbance** – Difficulty getting to or maintaining sleep.
42. **Social Skills** – Skills for managing interpersonal interactions successfully. Can include body language, verbal tone, assertiveness, and listening skills, among other areas.
43. **Speech and Language Problems** – Expressive and/or receptive language abilities substantially below expected levels as measured by standardized tests.
44. **Substance Abuse/Substance Use** – Issues related to the use or misuse of a common, prescribed, or illicit substances for altering mental or emotional experience or functioning.
45. **Suicidality** – Issues related to recurrent thoughts, gestures, or attempts to end one's life.
46. **Traumatic Stress** – Issues related to the experience or witnessing of life events involving actual or threatened death or serious injury to which the youth responded with intense fear, helplessness, or horror.
47. **Treatment Engagement** – The degree to which a family or youth is interested and optimistic about an intervention or plan, such that they act willfully to participate and work toward the success of the plan.
48. **Willful Misconduct/Delinquency** – Persistent failure to comply with rules or expectations in the home, school, or community. Excessive fighting, intimidation of others, cruelty or violence toward people or animals, and/or destruction of property.

### Progress Ratings

Please provide a single progress rating for each target selected above (up to 10). Numbers 1 through 10 in the left column refer to the targets selected in the Targets Addressed This Month section above. For example, had you selected “Academic Achievement” above, there would be a “1” in the box to the left of that target on that section. Then, the first row of the Progress Ratings, labeled “1,” is where you would note the progress ratings associated with academic achievement.

Please place a mark (X, ✓) in the column corresponding to your subjective rating of progress associated with this target. When possible, your overall subjective ratings should be informed by a review of objective measures such as any available and relevant questionnaires or behavioral observation data. For example, if a youth receives a T-score of 70 during an intake assessment and the treatment goal is to reduce this score to 60, then if a youth receives a T-score of 65 during a monthly assessment, then 50% progress may be reported [i.e.,  $70 - 65 / 70 - 60 = 5 / 10 = 50\%$ ]. Or if a youth gets into 10 fights per week initially and the treatment goal is to reduce fighting to 0 fights per week, then during a month in which the youth was fighting only 3 times per week, that would reflect 70% progress [i.e.,  $10 - 3 / 10 - 0 = 7 / 10 = 70\%$ ].

**Anchors refer to changes from baseline or beginning of services for that target.** Thus, a youth who had reached 90% of an initial goal would receive a rating of “significant improvement.” If that progress were to decline to 70% in the following month, the youth would then get a rating of “moderate improvement” for that target for that month (not “deterioration”). “Deterioration” refers to when a target gets worse from the time it was initially addressed. If there is a break in addressing a specific target (e.g., a target is addressed, then not addressed for a month, then addressed again in a later month), use the initial baseline from the first time as the

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

point of comparison. Only when there is a break in the complete episode of care (i.e., discharge followed by later admission), should that reset the baseline for a given target.

If a goal is reached (improvement is complete), the provider may choose to note the date in the rightmost column. This implies that the target is no longer being addressed. Targets that are not complete should be rated again on the following month's summary form.

### Intervention Strategies

Please place a mark (X, ✓) to the left of any intervention strategies used during the past month. There is no limit to how many may be checked. If strategies were employed that are not in the following list of definitions, please mark the "other" box and write in the strategy used.

### Definitions of Intervention Strategies

1. **Activity Scheduling** - The assignment or request that a child participate in specific activities outside of therapy time, with the goal of promoting or maintaining involvement in satisfying and enriching experiences.
2. **Assertiveness Training**-Exercises or techniques designed to promote the child's ability to be assertive with others, usually involving rehearsal of assertive interactions.
3. **Biofeedback/ Neurofeedback**-Strategies to provide information about physiological activity that is typically below the threshold of perception, often involving the use of specialized equipment.
4. **Catharsis**-Strategies designed to bring about the release of intense emotions, with the intent to develop mastery of affect and conflict.
5. **Cognitive/Coping**-Any techniques designed to alter interpretation of events through examination of the child's reported thoughts, typically through the generation and rehearsal of alternative counter-statements. This can sometimes be accompanied by exercises designed to comparatively test the validity of the original thoughts and the alternative thoughts through the gathering or review of relevant information.
6. **Commands/Limit Setting**-Training for caretakers in how to give directions and commands in such a manner as to increase the likelihood of child compliance.
7. **Communication Skills**-Training for youth or caretakers in how to communicate more effectively with others to increase consistency and minimize stress. Can include a variety of specific communication strategies (e.g., active listening, "I" statements).
8. **Crisis Management**-Immediate problem solving approaches to handle urgent or dangerous events. This might involve defusing an escalating pattern of behavior and emotions either in person or by telephone, and is typically accompanied by debriefing and follow-up planning.
9. **Directed Play**-Exercises involving the youth and caretaker playing together in a specific manner to facilitate their improved verbal communication and nonverbal interaction. Can involve the caretaker's imitation and participation in the youth's activity, as well as parent-directed play.
10. **Educational Support**-Exercises designed to assist the child with specific academic problems, such as homework or study skills. This includes tutoring.

11. **Emotional Processing**-A program based on an information processing model of emotion that requires activation of emotional memories in conjunction with new and incompatible information about those memories.
12. **Exposure**-Techniques or exercises that involve direct or imagined experience with a target stimulus, whether performed gradually or suddenly, and with or without the therapist's elaboration or intensification of the meaning of the stimulus.
13. **Eye Movement/ Tapping**-A method in which the youth is guided through a procedure to access and resolve troubling experiences and emotions, while being exposed to a therapeutic visual or tactile stimulus designed to facilitate bilateral brain activity.
14. **Family Engagement**-The use of skills and strategies to facilitate family or child's positive interest in participation in an intervention.
15. **Family Therapy**-A set of approaches designed to shift patterns of relationships and interactions within a family, typically involving interaction and exercises with the youth, the caretakers, and sometimes siblings.
16. **Free Association**-Technique for probing the unconscious in which a person recites a running commentary of thoughts and feelings as they occur.
17. **Functional Analysis**-Arrangement of antecedents and consequences based on a functional understanding of a youth's behavior. This goes beyond straightforward application of other behavioral techniques.
18. **Guided Imagery**-Visualization or guided imaginal techniques for the purpose of mental rehearsal of successful performance. Guided imagery for the purpose of physical relaxation (e.g., picturing calm scenery) is not coded here, but rather coded under relaxation (#42).
19. **Hypnosis**-The induction of a trance-like mental state achieved through suggestion.
20. **Ignoring or Differential Reinforcement of Other Behavior**-The training of parents or others involved in the social ecology of the child to selectively ignore mild target behaviors and selectively attend to alternative behaviors.
21. **Insight Building**-Activity designed to help a youth achieve greater self-understanding.
22. **Interpretation**-Reflective discussion or listening exercises with the child designed to yield therapeutic interpretations. This does not involve targeting specific thoughts and their alternatives, which would be coded as cognitive/coping.
23. **Line of Sight Supervision**-Direct observation of a youth for the purpose of assuring safe and appropriate behavior.
24. **Maintenance/Relapse Prevention**-Exercises and training designed to consolidate skills already developed and to anticipate future challenges, with the overall goal to minimize the chance that gains will be lost in the future
25. **Marital Therapy**-Techniques used to improve the quality of the relationship between caregivers.
26. **Medication/ Pharmacotherapy**-Any use of psychotropic medication to manage emotional, behavioral, or psychiatric symptoms.
27. **Mentoring**-Pairing with a more senior and experienced individual who serves as a positive role model for the identified youth.
28. **Milieu Therapy**-A therapeutic approach in residential settings that involves making the environment itself part of the therapeutic program. Often involves a system of privileges and restrictions such as a token or point system.

29. **Mindfulness**-Exercises designed to facilitate present-focused, non-evaluative observation of experiences as they occur, with a strong emphasis of being “in the moment.” This can involve the youth’s conscious observation of feelings, thoughts, or situations.
30. **Modeling**-Demonstration of a desired behavior by a therapist, confederates, peers, or other actors to promote the imitation and subsequent performance of that behavior by the identified youth.
31. **Motivational Interviewing**-Exercises designed to increase readiness to participate in additional therapeutic activity or programs. These can involve cost-benefit analysis, persuasion, or a variety of other approaches.
32. **Natural and Logical Consequences**-Training for parents or teachers in (a) allowing youth to experience the negative consequences of poor decisions or unwanted behaviors, or (b) delivering consequences in a manner that is appropriate for the behavior performed by the youth.
33. **Parent Coping**-Exercises or strategies designed to enhance caretakers’ ability to deal with stressful situations, inclusive of formal interventions targeting one or more caretaker.
34. **Parent-Monitoring**-The repeated measurement of some target index by the caretaker.
35. **Parent Praise**-The training of parents or others involved in the social ecology of the child in the administration of social rewards to promote desired behaviors. This can involve praise, encouragement, affection, or physical proximity.
36. **Peer Modeling/Pairing**-Pairing with another youth of same or similar age to allow for reciprocal learning or skills practice.
37. **Play Therapy**-The use of play as a primary strategy in therapeutic activities. This may include the use of play as a strategy for clinical interpretation. Different from Directed Play (#9), which involves a specific focus on modifying parent-child communication. This is also different from play designed specifically to build relationship quality (#41).
38. **Problem Solving**-Techniques, discussions, or activities designed to bring about solutions to targeted problems, usually with the intention of imparting a skill for how to approach and solve future problems in a similar manner.
39. **Psychoeducational-Child**-The formal review of information with the child about the development of a problem and its relation to a proposed intervention.
40. **Psychoeducational-Parent**-The formal review of information with the caretaker(s) about the development of the child’s problem and its relation to a proposed intervention. This often involves an emphasis on the caretaker’s role in either or both.
41. **Relationship/Rapport Building**-Strategies in which the immediate aim is to increase the quality of the relationship between the youth and the therapist. Can include play, talking, games, or other activities.
42. **Relaxation**-Techniques or exercises designed to induce physiological calming, including muscle relaxation, breathing exercises, meditation, and similar activities. Guided imagery exclusively for the purpose of physical relaxation is also coded here.
43. **Response Cost**-Training parents or teachers how to use a point or token system in which negative behaviors result in the loss of points or tokens for the youth.
44. **Response Prevention**-Explicit prevention of a maladaptive behavior that typically occurs habitually or in response to emotional or physical discomfort.
45. **Self-Monitoring**-The repeated measurement of some target index by the child.

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

46. **Self-Reward/Self-Praise**-Techniques designed to encourage the youth to self-administer positive consequences contingent on performance of target behaviors.
47. **Skill Building**-The practice or assignment to practice or participate in activities with the intention of building and promoting talents and competencies.
48. **Social Skills Training**-Providing information and feedback to improve interpersonal verbal and non-verbal functioning, which may include direct rehearsal of the skills. If this is paired with peer pairing (#36), that should be coded as well.
49. **Stimulus/Antecedent Control**-Strategies to identify specific triggers for problem behaviors and to alter or eliminate those triggers in order to reduce or eliminate the behavior.
50. **Supportive Listening**-Reflective discussion with the child designed to demonstrate warmth, empathy, and positive regard, without suggesting solutions or alternative interpretations.
51. **Tangible Rewards**-The training of parents or others involved in the social ecology of the child in the administration of tangible rewards to promote desired behaviors. This can involve tokens, charts, or record keeping, in addition to first-order reinforcers.
52. **Therapist Praise/Rewards**-The administration of tangible (i.e., rewards) or social (e.g., praise) reinforcers by the therapist.
53. **Thought Field Therapy**-Techniques involving the tapping of various parts of the body in particular sequences or "algorithms" in order to correct unbalanced energies, known as thought fields.
54. **Time Out**-The training of or the direct use of a technique involving removing the youth from all reinforcement for a specified period of time following the performance of an identified, unwanted behavior.
55. **Twelve-step Programming**-Any programs that involve the twelve-step model for gaining control over problem behavior, most typically in the context of alcohol and substance use, but can be used to target other behaviors as well.

For medication interventions please list each psychiatric medication the youth is taking (e.g., Adderall ER), describe the prescribed total daily dose for each medication (e.g., 30 mg.), identify the prescribed dose schedule (e.g., 2x/week, 3x/day, 15-10-5/day, etc.), place a check mark in the appropriate box if there was a change in the medication or regimen during the reporting month, and provide a description of the change on the line to the right (e.g., new medication, daily dosage change from 10 to 30 mg, change in dose schedule from 5-5/day to 10-10-10/day, etc.).

For Projected End Date, please indicate the expected date for termination of the services for which this form was completed.

For Discharged During Month please indicate if the youth was discharged from your program during the reporting month. If the youth was discharged, please indicate the Living Situation that the youth was entering upon discharge and the Reason for Discharge. For Projected End Date, please indicate the expected date for termination of the services for which this form was completed.



### Living Situation upon Discharge

Please place a mark (X, ✓) to the left of statement that best describes the type of living environment in which the youth was expected to reside at the time of discharge. Please select only one option. If the youth's living situation at discharge is not well described by the following list of definitions, please mark the "other" box and write in the youth's living situation.

1. **Home** - Youth to live in a house, apartment, trailer, hotel, dorm, barrack, and/or single room occupancy. This excludes situations better characterized as foster homes.
2. **Foster Home**-Youth to reside in a foster home or therapeutic foster home. A foster home is a home that is licensed to provide foster care to children, adolescents, and/or adults.
3. **Group Care**-Youth to reside in a group care facility. This level of care may include a group home, therapeutic group home, or board and care. This excludes community-based residential and hospital-based residential care
4. **Residential Treatment**- Youth to reside in a community-based residential treatment, rehabilitation center, or other residential treatment that is not better characterized as a group home or institution/hospital facility. An organization, not licensed as a psychiatric hospital, whose primary purpose is the provision of individually planned programs of mental health treatment services in conjunction with residential care for children and youth. The services are provided in facilities that are certified by state or federal agencies or through a national accrediting agency.
5. **Institutional/Hospital**-Youth resides in an institutional care or hospital-based residential care facility with care provided on a 24 hour, 7 day a week basis. This level of care may include a skilled nursing/intermediate care facility, nursing homes, institutes of mental disease, inpatient psychiatric hospital, psychiatric health facility, Veterans Affairs hospital, or state hospital.
6. **Jail/Correctional Facility**-Youth resides in a Jail and/or Correctional facility with care provided on a 24 hour, 7 day a week basis. This level of care may include a jail, correctional facility, detention centers, prison, youth authority facility, juvenile hall, boot camp, or boys ranch.
7. **Homeless/Shelter**- A youth is considered homeless if s/he lacks a fixed, regular, and adequate nighttime residence or his/her primary nighttime residency is a supervised publicly or privately operated shelter designed to provide temporary living accommodations, an institution that provides a temporary residence for individuals intended to be institutionalized, or a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings (e.g., on the street). Youth who were discharged due to extended runaway or elopement episode should be recorded in this category.

### Reason(s) for Discharge

Please place a mark (X, ✓) to the left of each statement that describes the reasons for discharging youth from the program during the reporting month. There is no limit to how many may be checked. If the discharge reason is not well characterized by the following list of definitions, please mark the "other" box and write in the reason.

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

1. **Success/Goals Met**-Youth was clinically discharged due to sufficient treatment progress (e.g., symptoms reduced, functioning improved), treatment goals were met, youth was evaluated and services were determined unnecessary, services were completed, or youth was moving to a less restrictive and intensive level of care.
2. **Insufficient Progress**-Youth was discharged from service without showing sufficient treatment progress to be judged as clinically successful (i.e., little symptom reduction, improvement in functioning, or goal attainment was achieved).
3. **Family Relocation**-Youth was discharge because the youth and family moved out of state or out of the service area.
4. **Runaway/Elopement**-Youth was discharged in association with an extended period of unavailability for treatment because the youth had runaway from home or eloped from the program.
5. **Refuse/Withdraw**-Youth was discharged due to parental refusal, non-participation in treatment, lack of consent, or other indication that client withdrew from services against professional advice.
6. **Eligibility Change**-Youth was discharged in association with a change in eligibility for services, such as a termination of a court order or commitment, aging out of child and adolescent services, loss of Medicaid insurance, etc.

Please provide any other Comments or Suggestions for the youth's care coordinator you think would be important.

If scores are available on any of the Outcome Measures recommended in the Interagency Practice Guidelines, please provide them along with dates in the optional section provided. Include whether or not youth was arrested during the past month, and an estimate of the percentage of school days that were attended. If school is attended in a residential setting, this counts toward the percentage of days attended.

For the CAFAS, the numbered spaces refer to the following scales: 1-School, 2-Home, 3-Community, 4-Behavior Towards Others, 5-Moods/Emotions, 6-Self-Harm, 7-Substance, 8-Thinking. "Total" refers to the sum of these 8 scales.

Please write the name of the agency including location (e.g., Maui, Big Island) and name of the clinicians (along with CAMHMIS ID#) and provider, along with appropriate signatures of the clinician completing the form and the qualified supervisor. Note the date that the form was submitted electronically to CAMHD and provide name of Care Coordinator.

---

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

---

### Agency Aggregated Data Form

Agency: \_\_\_\_\_

\* Please aggregate data from "Agency Quality Indicator Data Collection Tool" form at an agency level for each of the seven quality indicators, providing both the raw numbers (ex: 3 of 7) and percentage (ex: 43%) for each. Please round to nearest whole number.

1. Referral Acceptance Form Returned to FGC within 2 Working Days	2. Youth/young adult given a projected enrollment or admission date	3. <b>Services</b> are provided within 14 calendar days of referral	4. Youth/Young Adult ejected from service	5. Length of service in calendar days	6. Youth/young adult met a minimum of 75% of treatment goals at time of discharge

Please share any comments related to agency performance on above indicators:

1 \_\_\_\_\_

2 \_\_\_\_\_

3 \_\_\_\_\_

4 \_\_\_\_\_

5 \_\_\_\_\_

6 \_\_\_\_\_

---

Report Completed By:

Date Report Completed:

[illegible]

(10) Number of Staff Credentialed:	(11) Percentage of Staff Credentialed:
------------------------------------	--

**(1) Date of referral:** Complete referral packet is received from the FGC Branch. **(6) Reason for Ending Services:**

**(2) Referral Acceptance Form is sent to FGC:** Provider received referral, reviewed packet and sent to FGC Branch a completed Referral Acceptance Form within two working days of receipt of completed referral packet.

**(3) Projected enrollment or admission date:** Date agency agrees to begin providing services to youth or young adult. If admission date is not provided, indicate "W" if waitlisted, "R" if rejected, or "OTH" for other (provide explanation).

**(4) Services are delivered within 14 calendar days:** A “Y” indicates that youth or young adult received services within 14 calendar days from the date of referral (defined above). A “N” indicates that services did not begin within 14 days of referral. Services must be delivered through face-to-face contact with client by provider or program. Admission interviews should not be considered for service delivery.

**(5) Date services ended:** If client services end during the reporting quarter, please provide the date that services stopped (i.e. discharge date). Youth may have been admitted during any previous quarter.

**(6) Reason for Ending Services:**

b. Elopement

#### d. Consent to Treat Rescinded

e. Family Moved

f. Other (provide explanation)

(7) **Youth ejected:** If the client's services ended during the quarter, a "Y" indicates that the decision was made against the advice of the CSP team (members include: FGC, DHS, DOE, FC etc.). An "N" indicates that the agency's decision to discharge youth was made in agreement with the CSP team.

**(8) Length of service:** Number of Calendar Days between youth/young adult's enrollment/admission and the date that services ended (i.e., discharge date).

**(9) Treatment goals met:** If client is discharged, a "Y" would indicate that client met at least 75% of his/her Mental Health Treatment Plan Goals as evidenced by the CAMHD Provider Monthly Summary and has been clinically discharged. An "N" indicates that client did not meet 75% of treatment plan goals at the time of discharge.

**(10) Number of staff credentialed:** Total number of staff that were credentialed through CAMHD within the quarter.

**(11) Percentage of staff credentialed:** Denominator: Total number of staff requiring CAMHD credentialing within the quarter. Numerator: Total number of staff that were credentialed prior to working with CAMHD youth within the quarter.

**Therapeutic Foster Home Profile Form**

1. Agency Name:
2. Agency Contact Name & Number: Date:
3. Foster Family Name:
4. Foster Family geographic location:
5. Foster Family preference or exclusions for foster youth (if any including age, gender, diagnosis, etc):
6. Foster Family length of experience as TFH:
7. Foster Family current number, age and sex of foster youth:
8. Foster Family current number, age and sex of biological youth:
9. Foster Family, maximum number of foster youth willing to take:
10. Foster Family strengths:
11. Foster Family weaknesses:

Comments:

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT: Sentinel Events</b>	<b>Number:</b>	<b>80.805</b>
	<b>Page</b>	<b>1 of 5</b>

<b>REFERENCE:</b> JCAHO; CARF; COA; 45 C.F.R. §164.502(b)(1); 34 C.F.R. Part 99; HRS 334-5, HRS §350-1.1, HRS §350-1.2, Confidentiality of Records, CAMHD P&P 80.402, "Confidentiality, FAX Transmission."	<b>APPROVED:</b>	
	<b>Signature on File</b> Chief	11/15/05 Eff. Date

### PURPOSE

To establish uniform guidelines for a reporting system that is designed to track and document sentinel events and the follow-up of the events reported by the Child and Adolescent Mental Health Division (CAMHD) Branches and contracted provider agencies (Provider).

### DEFINITIONS

**Sentinel Event** - An occurrence involving serious physical or psychological harm to anyone or the risk thereof, as defined under the categories of sentinel event codes and definitions. A sentinel event includes 1) any inappropriate sexual contact between youth, or credible allegation thereof; 2) any inappropriate, intentional physical contact between youth that could reasonably be expected to result in bodily harm, or credible allegation thereof; 3) any physical or sexual mistreatment of a youth by staff, or credible allegation thereof; 4) any accidental injury to the youth or medical condition requiring attention by a medical professional or transfer to a medical facility for emergency treatment or admission; 5) medication errors and drug reactions; 6) any fire, spill of hazardous materials, or other environmental emergency requiring the removal of youth from a facility; or 7) any incident of elopement by a youth.

**Critical Events** - Events involving serious injury or death, suicidal attempts, sexual misconduct, allegations of staff abuse or misconduct.

**Incident** - An occurrence that is a safety issue that is minor in nature and does not require major medical or staff intervention and is not identified as a reportable event as defined in the sentinel event codes and definitions. Incidents as defined here should be recorded and tracked internally, but do not need to be reported to CAMHD Sentinel Events Specialist (SES).

**Root Cause Analysis** - A process for identifying the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause analysis focuses primarily on systems and processes, not individual performance. It progresses from special causes in clinical processes to common causes in organizational processes and identifies potential improvements in processes or

REVISION HISTORY: March 31, 2003  
Initial Effective Date: July 1, 2001

File Ref:  
A6432

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

SUBJECT: Sentinel Events	Number:	80.805
	Page	1 of 5

systems that would tend to decrease the likelihood of such events in the future, or determines, after analysis, that no such improvement opportunities exist.

The product of the root cause analysis is an ***action plan*** that identifies the strategies that the organization intends to implement to reduce the risk of similar events occurring in the future. The plan should address responsibility for implementation, oversight, pilot testing as appropriate, time lines, and strategies for measuring the effectiveness of the actions.

***Individually Identifiable Health Information*** - Information that is a subset of protected health information, including demographic information collected from an individual, and: (1) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) Relates to the past, present, or future physical or mental health condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual, and that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

***Protected Health Information*** - Individually identifiable health information that is transmitted by electronic media or maintained in electronic form/medium. Protected health information excludes individually identifiable health information in: (1) Education record covered by the Family Educational Rights and Privacy Act (FERPA) as amended by 20 U.S.C. 1232g; (2) Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); and (3) Employment records held by a covered entity in its role as employer. CAMHD client clinical records, and those of its contracted providers, are considered “educational records” that come under FERPA authority. However, for the purpose of reporting a sentinel event, individually identifiable health information will be exchanged following HIPAA guidelines for handling PHI.

***Minimum Necessary*** applies. When using or disclosing protected health information or *when requesting protected health information from another covered entity, a covered entity must make reasonable efforts to limit protected health information to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.*

### POLICY

1. Providers shall document and report all sentinel events to the CAMHD Performance Management Office’s Sentinel Events Specialist (SES), and to the applicable Branch where youth is registered. All events that occur during the period a youth is receiving services must be reported, including events not witnessed directly by the Provider’s staff.

REVISION HISTORY: March 31, 2003  
Initial Effective Date: July 1, 2001

File Ref:  
A6432

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT: Sentinel Events</b>	<b>Number:</b>	<b>80.805</b>
	<b>Page</b>	<b>1 of 5</b>

Providers are required to track and analyze the occurrence of both sentinel events and incidents as part of their quality improvement program to identify areas of need for changes in general operations, program, staffing, training, or supervision. Results of these analyses shall be reported in the Providers' *Quarterly Quality Improvement Report* to CAMHD.

2. The CAMHD sentinel events reporting system shall allow for clinical and administrative oversight as well as provision of data utilized towards preventive interventions.
3. The Provider shall immediately establish a safe and therapeutic environment following any event in which the safety of youth, family, community members, or staff, is compromised.
4. The Provider will review the sentinel event to determine:
  - A. Triggers that caused the event to occur; and
  - B. Root causes of the sentinel event.
5. The Provider will complete:
  - A. A detailed assessment and analysis of the sentinel event, including the identification of triggers and root causes; and
  - B. A time-limited plan or strategy that allows the primary agency or party with oversight authority to adopt and implement a corrective course of action that reduces the probability of similar events reoccurring with any youth.

### PROCEDURE

1. When a sentinel event occurs the Provider shall notify the SES, the youth's legal guardian, and the youth's assigned Mental Health Care Coordinator (MHCC) within twenty-four (24) hours of the occurrence of the sentinel event, either by phone or fax. Any fax transmissions that contain protected health information about consumers shall follow protocol pursuant to *CAMHD P&P 80.402, "Confidentiality, FAX Transmission."*
2. Providers shall report all sentinel events using CAMHD's standard *72 Hour Sentinel Event Report* form (*See Attachments A and B*) by a confidential fax to the SES, and MHCC within ***seventy-two (72) hours*** of the sentinel event by fax (733-9357). The documentation shall include:
  - A. A written description of the event,
  - B. Youth's name, date of birth,
  - C. Immediate actions taken,
  - D. Review and identification of precipitating events,

REVISION HISTORY:      March 31, 2003  
Initial Effective Date:      July 1, 2001

File Ref:  
A6432



# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT: Sentinel Events</b>	<b>Number:</b>	<b>80.805</b>
	<b>Page</b>	<b>1 of 5</b>

- E. Analysis of actions on the part of staff that may have reduced the severity of the occurrence, and
  - F. Action that will be or have been taken in the attempt to prevent future similar occurrences.
- 3. In cases of critical events involving serious injury or death, suicidal attempts, sexual misconduct, allegations of staff abuse or misconduct, the Provider shall report such event by telephone to SES *within two (2) hours* of event occurrence.
- 4. The SES shall immediately notify the Supervisor of critical safety/risk management concerns. Critical events involving serious injury or death, suicidal attempts, or rape, may require immediate on-site investigations conducted by the Performance Management Reviewers; or at the very least, immediate information, guidance, and requests of the Provider are conducted in writing or by telephone.
- 5. The Performance Management Office will conduct an investigation of critical events within thirty (30) calendar days for the following critical sentinel events:
  - A. Suicide,
  - B. Homicide,
  - C. Accidental death,
  - D. Serious physical injury requiring hospitalization, and
  - E. Rape.
- 6. The CAMHD Performance Manager and Medical Director shall convene a team of CAMHD professionals and others to conduct a root cause analysis of a critical event. Providers will participate in the root cause analysis and provide all relevant information requested by the team as appropriate.
  - A. Members of the team shall include at the minimum:
    - 1) A licensed clinical mental health professional,
    - 2) A quality assurance specialist,
    - 3) An administrator, and
    - 4) Other representatives to assure all parties involved participate in the Root Cause Analysis.
  - B. The Performance Manager will prepare a formal written report of the investigation and its findings, including the root cause analysis and the Provider's Action Plan for review by the Chief of CAMHD and by CAMHD Safety and Risk Management Committee (SARM).

REVISION HISTORY:      March 31, 2003  
Initial Effective Date:      July 1, 2001

File Ref:  
A6432

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT: Sentinel Events</b>	<b>Number:</b>	<b>80.805</b>
	<b>Page</b>	<b>1 of 5</b>

- C. The Performance Manager will prepare a final written report of the findings and recommendations that will be distributed to all applicable CAMHD sections, including Branches. Performance Management reviewers shall follow-through and monitor required documents and adequacy of corrective action from the agency.
7. The Provider's Clinical Director shall review and provide comments to each *72 Hour Sentinel Event Report* to ensure legibility, accuracy, completeness, and clinical/administrative adequacy prior to its release to CAMHD.
8. Providers shall maintain a systematic log of their sentinel events on a manual or electronic database to generate reports to conduct their internal reviews and analyses. Aggregate analyses, findings and actions taken to reduce frequency of occurrences shall be a part of the agency's overall Quarterly Quality Improvement Report submitted to CAMHD. Further, comparisons shall be made of each ensuing quarter against previous quarters' findings.
9. The SES shall maintain a log of all sentinel notifications to determine whether further information is necessary in instances where immediate action by the Provider and CAMHD is warranted.
10. The SES shall track the timeliness and adequacy of Providers' *72-Hour Sentinel Event Reports*. The SES shall consult with or inform the appropriate Performance Management Office or Clinical Services Office clinician as necessary.
11. The SES shall maintain an electronic database of all sentinels reported by Providers or Branches. Various reports are aggregated from data fields sorted by Provider with comparisons among all Providers of like services on a quarterly basis. CAMHD's SARM Committee, and the Performance Improvement Steering Committee (PISC) shall review these reports. Additionally, such reports are also incorporated into CAMHD's quarterly report to Med-QUEST Division.
12. The SES shall generate full detailed reports for Performance Management reviewers in preparation for the Provider agencies' case-based reviews.
13. The Performance Management Reviewers shall conduct desk reviews or on-site reviews of Providers' system of tracking and analyses in full detail of incidents whenever special investigations, regular provider agency case-based reviews, or licensing reviews are conducted.

### ATTACHMENTS

- A. 72-Hour Sentinel Event Report Form  
B. Sentinel Event Code Definitions

REVISION HISTORY: March 31, 2003  
Initial Effective Date: July 1, 2001

File Ref:  
A6432

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### Child & Adolescent Mental Health Division State of Hawaii Department of Health 72-HOUR SENTINEL EVENT REPORT

*Under CAMHD guidelines, a sentinel event is an occurrence involving serious physical and/or psychological harm or the risk thereof. A separate form is required for each singular event within 72 hours of the event occurrence. A 24-hour verbal report is also required to the case Mental Health Care Coordinator (MHCC) as well as to the CAMHD Sentinel Events Specialist at 733-9356.*

***Fax to: Sentinel Events Specialist at 733-9357 and fax to Family Guidance Center (FGC) MHCC at the appropriate FGC fax number. Pages 1 and 2 to be completed by staff witnesses involved.***

**Agency:** \_\_\_\_\_ **Program Name:** \_\_\_\_\_ **Provider ID#:** \_\_\_\_\_  
**Street Address** (residential facilities only): \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Island:** \_\_\_\_\_ **Reported By:** \_\_\_\_\_ **Date Reported:** \_\_\_\_\_  
**Level of Service (check one):** ☐ Hospital-Based Residential ☐ Intensive In-Home  
☐ Multi-Systemic Therapy ☐ Therapeutic Foster Home  
☐ Community Based Residential ☐ Therapeutic Group Home  
☐ Community Based Residential-High Risk ☐ Crisis Residential  
☐ Other: \_\_\_\_\_

**MHCC:** \_\_\_\_\_ **Family Guidance Center:** \_\_\_\_\_  
**Youth's Last Name:** \_\_\_\_\_ **Youth's First Name:** \_\_\_\_\_  
**CAMHD CR#:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Event Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_ am/pm

- ☐ Check here if event occurred when youth was not under direct care of program or staff (e.g., family outing, in school, etc.)
- ☐ MHCC Notified of Event ☐ Personal Notification of Parent or Legal Guardian

#### DESCRIPTION OF EVENT

**A.** *Describe the location and scene (what activity youth(s) engaged in):*

**B.** *Summarize what occurred (attach additional sheet, if necessary)*

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

- C. *Precipitating Factors/Antecedents (What happened prior to this event?):*
- D. *Names/titles of participants engaged in this event (submit separate report for other CAMHD youth involved):*
- E. *Any type of follow-up planned for staff or youth witnesses affected by event:*
- F. *How did event end (status of the youth/staff):*

### EVENT CODES

CLIENT CR#: \_\_\_\_\_

**G. Check all that apply** (\* indicates reporting required only for CAMHD out-of-home placements):

### CHILD EVENTS

#### Person Directed – Youth is the perpetrator

- 1 \* Sexually Inappropriate Behavior – consensual, while in CAMHD out-of-home placement
- 2 Sexually Inappropriate Behavior – non-consensual
- 3 Physical Assault I
- 4 Physical Assault II – homicidal intent or potentially fatal
- 5 Homicide
- 6 Sexual Assault I
- 7 Sexual Assault II – penetration through coercion or threat of force
- 8 NOS/Other:

#### Intentional Self-Inflicted Injury

- 16 Refusal of Life Preserving Medical Treatment
- 17 \* Medication Refusal – only report 2<sup>nd</sup> consecutive refusals
- 18 Suicidal Ideation
- 19 Suicidal Threat – verbal or gestural
- 20 Non-Lethal Injury – minor attention needed
- 21 Non-Lethal Injury – medical attention needed
- 22 Potentially Lethal Injury or Hospitalization
- 23 Suicide
- 24 NOS/Other: \_\_\_\_\_

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### Substance Use

- 9 \* Alcohol, Illicit Drugs, or Other Irregular use of Chemicals - while in CAMHD out-of-home placement
- 10 Accidental Overdose (intentional is coded as a self injury)
- 11 NOS/Other: \_\_\_\_\_

### Property Directed

- 12 Theft – replacement value greater than \$50
- 13 Destruction/Assault of Property – requiring crisis or authority intervention
- 14 Possession of Weapons or Hazardous Items
- 15 NOS/Other: \_\_\_\_\_

### Escape or Avoidance Behavior

- 25 Runaway – while in family or non-CAMHD placement and gone for 24-hours or more
- 26 \* Elopement -while in CAMHD out-of-home placement and gone for 1 hour or more
- 27 NOS/Other: \_\_\_\_\_

### Aberrant Behavior

- 28 Aberrant Behavior - active psychosis
- 29 NOS/Other: \_\_\_\_\_

### Allegations – made only by youth with no witnesses

- 30 Verbal Abuse of Youth by Staff
- 31 Physical Abuse of Youth by Staff
- 32 Physical Abuse of Youth by Non-Agency Individual
- 33 Sexual Abuse of Youth by Staff
- 34 Sexual Abuse of Youth by Non-Agency Individual
- 35 NOS/Other: \_\_\_\_\_

## INSTITUTIONAL EVENTS

### Person Directed – Youth is the victim

- 36 Client Assaulted or Injured by Peer – medical attention needed
- 37 Client Sexually Assaulted by Peer
- 38 Client Assaulted or Injured by Non-Agency Adult – minor attention needed
- 39 Client Assaulted or Injured by Non-Agency Adult – medical attention needed
- 40 Client Sexually Assaulted by Non-Agency Adult

### Interventions

- 42 Restraint – physical hold or escort  
Start time: \_\_\_\_\_ End Time: \_\_\_\_\_
- 43 Restraint - mechanical Start: \_\_\_\_\_ End: \_\_\_\_\_
- 44 Restraint – chemical  
name of med: \_\_\_\_\_
- 45 ☐ Medication used for Control –  
name of med: \_\_\_\_\_
- 46 Hospitalization
- 47 Seclusion –Start time: \_\_\_\_\_ End time: \_\_\_\_\_
- 48 Police Called – no charges filed
- 49 Criminal Charges Filed or Arrest
- 50 NOS/Other: \_\_\_\_\_

### Youth Injury

- 51 Non-Agency Medication Error
- 52 Staff Medication Error
- 53 Youth Injured – requiring immediate medical attention
- 54 Youth Injured – requiring hospitalization
- 55 Death of a Client
- 56 NOS/Other: \_\_\_\_\_

### Staff Injury

- 57 Staff Injured – requiring medical attention
- 58 Staff Injured During Seclusion or Restraint – requiring minor attention
- 59 Staff Injured During Seclusion or Restraint – requiring medical attention
- 60 NOS/Other: \_\_\_\_\_

### Allegations – corroborated by a person other than youth

- 61 Verbal Abuse of Youth by Staff
- 62 Physical Abuse of Youth by Staff
- 63 Physical Abuse of Youth by Non-Agency Individual
- 64 Sexual Abuse of Youth by Staff
- 65 Sexual Abuse of Youth by Non-Agency Individual
- 66 NOS/Other: \_\_\_\_\_

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

H. *Additional post event comments:*

I. *Root causes hypothesized (Intrinsic to youth? External – environmental, staff, etc.):*

J. *Could this event have been avoided? How?*

K. *Specific changes planned or implemented regarding the youth's treatment plan, staff, program, physical structure, operations, etc. to reduce the probability of reoccurrence (include results of both debriefing sessions). Check all that apply and provide additional written explanation below:*

- 01 ☐ Repeat Occurrence – Heighten Monitoring
- 02 ☐ Multiple Repeat Occurrence – Address in Treatment Plan
- 03 ☐ 1:1 Monitoring by Staff, duration: \_\_\_\_\_
- 04 ☐ Therapist Notified
- 05 ☐ Schedule Treatment Team Meeting
- 06 ☐ Assessment Scheduled
- 07 ☐ Room Change
- 08 ☐ Detained at Correctional Facility
- 09 ☐ Probation Officer Notified

- 010 ☐ Appointment with Primary Care Physician
- 011 ☐ Appointment with Psychiatrist
- 012 ☐ Consult with Doctor Regarding Medication
- 013 ☐ Consult Program RN
- 014 ☐ Medical Attention Provided
- 015 ☐ Admin Review of Policy and Procedures
- 016 ☐ Programmatic Changes Made
- 017 ☐ Staff Training Scheduled
- 018 ☐ Police Report Made
- 019 ☐ CPS Report Made

**Narrative:**

Clinical Director Print Name:

Date:

*\*If designee, indicate position and discipline title. Phone: \_\_\_\_\_ e-mail address: \_\_\_\_\_*

Signature:

**SENTINEL EVENT CODE DEFINITIONS****Youth Events**

Youth events generally occur due to choices made by the youth and often involve target behaviors. These events are divided into 7 subcategories:

- Person Directed,
- Self-Injury,
- Substance Use,
- Property Directed,
- Aberrant Behavior
- Escape/Avoidance Behaviors, and
- Allegations Made by the Youth (this category describes events reported by the youth without witnesses or corroboration from another individual).

**Person Directed Definitions – Youth is the Perpetrator**

1.	Sexually Inappropriate Behavior – consensual, while in CAMHD out-of-home placement	Inappropriate sexual behavior or non-penetrating sexual acts. Others involved must be willing participants or observers. Does not include acts with participants/observers who are 3 or more years younger. <i>This code only needs to be reported for youths in a Child and Adolescent Mental Health Division out of home placement.</i>
2.	Sexually Inappropriate Behavior –non-consensual	Inappropriate sexual behavior involving other non-consenting individuals. Includes events involving physical contact and events without any contact. e.g., exposure, verbally inappropriate behavior, sexually suggestive gestures, standing too close in an elevator, inappropriate hugging, etc.
3.	Physical Assault I	A violent physical attack or attempt to inflict offensive physical contact or bodily harm that puts the person in immediate danger of such harm or contact. Does not include incidents that fall under Assault II category.
4.	Physical Assault II – homicidal intent or potentially fatal	A violent physical attack or attempt to inflict offensive physical contact or bodily harm that puts the person in immediate danger of such harm or contact. Act must include homicidal intent or be potentially fatal.
5.	Homicide	Killing of one person by another.
7.	Sexual Assault II – penetration through coercion by threat of force	Act of engaging in non-consensual penetration with another through coercion or threat of force.
8.	NOS/Other	Other person directed events not described by above definitions.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### Substance Use – Self Administered or Non-professionally Administered

9.	Alcohol or Other Irregular use of Chemicals - while in CAMHD out-of-home placement	Possession or use of alcohol, drugs, or other illicit or poisonous natural or synthesized substances. Includes consumption of legal substances in way not intended for use (sniffing glue, etc.).
10.	Accidental Overdose (intentional overdose coded as self injury)	Consumption of alcohol, drugs, tobacco, or other illicit or poisonous natural or synthesized substances requiring medical attention.
11.	NOS/Other	Other substance abuse events not described by above definitions.

### Property Directed

12.	Theft	Any type of stealing or theft of an item with a replacement value greater than \$50.
13.	Destruction/Assault of Property	Destruction of personal possessions, physical structures, furnishings, or other such property requiring crisis or authority intervention (police called, charges pressed, etc.).
14.	Possession of Weapons or Hazardous Items	Possession of a prohibited item or weapon with the potential to inflict serious harm to persons or property.
15.	NOS/Other	Other property directed events not described by above definitions.

### Intentional Self-Inflicted Injury

16.	Refusal of Life-Preserving Medical Treatment	Refusal to receive recommended, life-preserving medical treatment other than medication.
17.	Medication Refusal –	Second consecutive refusal by youth to take medication as prescribed. Do not combine multiple days on one report, each day must be reported separately.
18.	Suicidal Ideation	Expression of thoughts to harm self (verbal, gestures, drawings, letters, etc.).
19.	Suicidal Threat – verbal or gestural	Immediate serious threat with a plan to harm.
20.	Non-Lethal Injury – minor attention needed	Self-inflicted, non-lethal, injury without the potential to end one's life which does not require hospital emergency medical attention.
21.	Non-Lethal Injury – medical attention needed	Self-inflicted, non-lethal, injury without the potential to end one's life which requires immediate medical attention.
22.	Potentially Lethal Injury or Hospitalization	Self-inflicted injury with the intention or potential to end one's life requiring hospitalization - or - requiring immediate care and attention of a qualified physician, and which, if not treated immediately, would jeopardize or impair the health of the child.
23.	Suicide	Intentionally ending own life.
24.	NOS/Other	Other self-injury events not described by above definitions.



## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### Escape or Avoidance Behavior

25.	Runaway - while residing in family home or other non-CAMHD placement	Removing self from supervision for 24-hours without permission while residing with natural family, DHS foster home, or other placement not contracted through Child and Adolescent Mental Health Division.
26.	Elopement - while residing in CAMHD Out-Of-Home placement	Removing self from supervision without permission for an hour or more while residing in a Child and Adolescent Mental Health Division out-of-home placement, such as therapeutic foster home, group home, etc. Only report incidents of truancy where the youth is not present at the expected time.
27.	NOS/Other	Other escape or avoidance behavior events not described by above definitions.

### Aberrant Behavior

28.	Aberrant Behavior	Severe behavior involving dissociated behavior or possible psychosis that does not fit into another event category.
29.	NOS/Other	Other aberrant behavior not described by above definition.

### Allegations – Made Only by Youth

Allegations that are only made by the youth with no witnesses or others involved who can corroborate the allegation.

30.	Verbal Abuse of Youth by Staff	Youth alleges staff member of reporting agency makes inappropriate verbal or gestural contact.
31.	Physical Abuse of Youth by Staff	Youth alleges physical abuse from staff member of reporting agency. Includes hair pulling, pushing, or inappropriate methods of restraint (like grabbing shirt).
32.	Physical Abuse of Youth by Non-Agency Individual	Youth alleges physical abuse from individual that is not a staff member of reporting agency.
33.	Sexual Abuse of Youth by Staff	Youth alleges sexual abuse from staff member of reporting agency.
34.	Sexual Abuse of Youth by Non-Agency Individual	Youth alleges sexual abuse from individual that is not a staff member of reporting agency.
35.	NOS/Other	Other allegations made by the youth not described by above definitions.

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### Institutional Events

Institutional events are events that happen to the youth or occur as a consequence of youth behavior. These events generally occur due to choices made by individuals other than the youth. These events are divided into 5 subcategories:

- Person Directed,
- Treatment Interventions,
- Client-Injury,
- Staff Injury, and
- Allegations made by person other than the child (this category does not include events only reported by the child without corroboration from another individual).

#### **Person Directed – Youth is the Victim**

36.	Youth Assaulted or Injured by Peer – medical attention needed	Physical mistreatment by peer(s) requiring medical attention or hospitalization.
37.	Youth Sexually Assaulted by Peer	Youth sexually assaulted or mistreated by peer(s).
38.	Youth Assaulted or Injured by Non-Agency Adult - minor attention needed	Physical mistreatment by adult not employed by reporting agency - not requiring medical attention.
39.	Youth Assaulted or Injured by Non-Agency Adult - medical attention needed	Physical mistreatment by adult not employed by reporting agency - requiring medical attention or hospitalization.
40.	Youth Sexually Assaulted by Non-Agency Adult	Youth sexually assaulted or mistreated by adult not employed by reporting agency.
41.	NOS/Other	Other person directed events not described by above definitions.

#### **Interventions**

42.	Restraint - physical hold or escort  Duration:	Involves the application of physical force without the use of any device, for the purpose of restricting freedom of movement. Brief 'personal holds' without undue force for the purpose of comforting, or holding an individual's hand or arm for safe escort to another area is not considered a restraint. Physical escorts in which the youth is willfully cooperating with the guide is not considered restraint until such a time as the youth no longer intends to follow or be escorted (e.g., youth struggles with staff). Excludes physical separation of two individuals by placing body between them to prevent physical altercation. There are no distinguishing time limits.
43.	Restraint - mechanical  Duration:	Involves the use of any restraining device attached or adjacent to the youth's body (e.g., four point bed restraints) that restricts a youth's movement. There are no distinguishing time limits.
44.	Restraint - chemical	Involves the incidental use of medications and drugs to control acute unsafe behavior through temporary sedation or other related

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	Name of medication:	pharmacological action. Does not include PRN. Please specify the type of medication administered.
45.	Medication used for Control Name of medication:	Any medication given urgently for emotional or behavioral control such as NOW or STAT orders. Please specify the type of medication administered. * For in-home services, it is only necessary to report those events requiring crisis intervention.
46.	Hospitalization	Acute and emergent admission to the hospital for psychiatric reasons.
47.	Seclusion  Duration:	The involuntary confinement of a youth in a locked and/or secure room to ensure the safety of the youth or others. Any such isolation in a secure environment from which the youth is not potentially free to leave is considered seclusion (e.g., having a staff member block the exit from the unlocked seclusion room).
48.	Police Called – No Charges Filed.	Police are called and no charges are filed.
49.	Criminal Charges Filed or Youth is Arrested	Police called and charges filed - or - Youth is arrested. Excludes instances of calling the police when used as a planned treatment intervention previously decided by treatment team and written into the individual treatment plan.
50.	NOS/Other	Other interventions not described by above definitions.

### Youth Injury

This section refers to those events where the reason for occurrence is other than an assault against the youth. Events that involve the assault of a youth should be coded as Person Directed Institutional Events.

51.	Non-Agency Medication Error	Any error in making medication available to youth by a non-agency individual. This includes dispensing errors made while youth is on pass.
52.	Staff Medication Error	Any error in making medication available to youth by an agency individual/staff. Includes forgetting medication, giving wrong medication, and discovering medication count is different from medication log.
53.	Youth Injured - requiring immediate medical attention	Injury to youth, not intentionally self-inflicted, and requiring immediate medical attention
54.	Youth Injured - requiring hospitalization	Injury to youth, not intentionally self-inflicted, with the potential to end one's life requiring hospitalization for non-psychiatric reasons - or - requiring immediate care and attention of a qualified physician, and which, if not treated immediately, would jeopardize or impair the health of the youth.
55.	Death of Youth	Death from any cause.
56.	NOS - non-injury related (i.e. seizure)	Other significant events requiring medical attention not classified by above categories, including non-injury related events (e.g., medical complications).

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### Staff Injury

57.	Staff Injured - medical attention required	Program related or youth caused injury to staff requiring medical attention. Does not include injuries that occur during a seclusion or restraint.
58.	Staff Injured During Seclusion or Restraint - minor attention required	Injury to staff that occurs during a seclusion or restraint requiring no medical attention.
59.	Staff Injured During Seclusion or Restraint - medical attention required	Injury to staff that occurs during a seclusion or restraint requiring medical attention.
60.	NOS/Other	Other staff injury events not described by above definitions.

### Allegations – Corroborated by a Person Other than Youth

Allegations made by the youth and there are witnesses or others involved who can corroborate the allegation. Allegations made by others concerning the youth also fall under this category.

61.	Verbal Abuse of Youth by Staff	Alleged inappropriate verbal or gestural contact from staff member of reporting agency.
62.	Physical Abuse of Youth by Staff	Alleged inappropriate physical abuse from staff member of reporting agency. Includes hair pulling, pushing, or inappropriate methods of restraint (like grabbing shirt).
63.	Physical Abuse of Youth by Non-Agency Individual	Alleged inappropriate physical abuse from individual that is not a staff member of reporting agency.
64.	Sexual Abuse of Youth by Staff	Alleged sexual abuse from staff member of reporting agency.
65.	Sexual Abuse of Youth by Non-Agency Individual	Alleged sexual abuse from individual that is not a staff member of reporting agency.
66.	NOS/Other	Other allegations made by person other than youth not described by above definitions.

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

Child and Adolescent Mental Health Division

State of Hawaii -- Department of Health

## Weekly Census Report on Client Status

**Agency:** 
**Program:** 
**For:**

Month	Day	Year
<input type="text"/>	<input type="text"/>	2002

*Use **Separate** sheet for each program*
*Due **before** close of business day each Monday*

Prepared By:
Contact phone #

No of Beds currently available	Age	Gender	Sub LOC	Specialty	General Location	Other

### FAMILY GUIDANCE CENTERS CODES:

<b>CO</b> Central Oahu	<b>HNL</b> Honolulu, Oahu	<b>LO</b> Leeward Oahu	<b>WO</b> Windward Oahu
<b>H</b> Hawaii	<b>K</b> Kauai	<b>M</b> Maui	

WAIT LIST	
*Yes <input type="checkbox"/>	No <input type="checkbox"/>
* If Yes, Must attach current wait list	

**Note :** All columns must be completed as appropriate

Date of Admission	Client's Name LN, FN	Gender M or F	Sub Loc	Referring FGC	Projected Date of Discharge	Actual Date of Discharge	Discharge Placement	Wait Listed Date	Projected Date of Admission	Other Agencies Involved	Other Comments

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

Child and Adolescent Mental Health Division

State of Hawaii -- Department of Health

## WAITLISTED YOUTH FORM

Facility: <input style="width: 150px; height: 25px;" type="text"/>	Program: <input style="width: 150px; height: 25px;" type="text"/>	For: <table style="display: inline-table; border: 1px solid black; text-align: center; width: 50px;">Month</table> <table style="display: inline-table; border: 1px solid black; text-align: center; width: 50px;">Day</table> <table style="display: inline-table; border: 1px solid black; text-align: center; width: 50px;">Year</table>	Prepared By: <input style="width: 120px; height: 30px;" type="text"/>
	<i>Use Separate sheet for each program</i>	<i>Due <b>before</b> close of business day each Monday</i>	Contact #: <input style="width: 120px; height: 30px;" type="text"/>

<b>CO</b>	Central Oahu	<b>HNL</b>	Honolulu, Oahu	<b>LO</b>	Leeward Oahu	<b>WO</b>	Windward Oahu
<b>H</b>	Hawaii	<b>M</b>	Maui	<b>K</b>	Kauai		

**Note : All columns must be completed as appropriate**

Client's Name LN, FN	FGC	Gender M or F	D.O.B	Diagnosis	Current Placement	Date Waitlisted	Projected Date of Admission	Sub Level of Care Needed	Other Agencies Involved	Waitlisted Region

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

Excel format

## STATE OF HAWAII CAMHD-DOE EDUCATION ATTENDANCE REPORT

Monthly School Attendance Record

Date: \_\_\_\_\_ Page \_\_\_\_\_ of \_\_\_\_\_  
 Provider: \_\_\_\_\_ Type of Program: \_\_\_\_\_ Teacher(s): \_\_\_\_\_  
 Service Code: \_\_\_\_\_

	List Alphabetically  Name (Last Name, First Name)	Home School	Select One IDEA/504	Current IEP/MP/Date	ESY Yes/No	Week 1					Week 2					Week 3					Week 4					Week 5					Total Days Present	
						M	Tu	W	Th	F	M	Tu	W	Th	F	M	Tu	W	Th	F	M	Tu	W	Th	F	M	Tu	W	Th	F		
1																																
2																																
3																																
4																																
5																																
6																																
7																																
8																																
9																																
10																																
11																																
12																																
13																																
14																																
15																																
Totals by Day																																
																										Monthly Total						

"E" = Date entered program. "L" = Date Left/Exited Program, Not Included in Count.

P = Present, Educational Services Received. "A" = Absent. ESY = Extended School Year.

Signature \_\_\_\_\_

Provider's Signature - Verifying all information provided above is correct. Date \_\_\_\_\_

District Education  
Specialist Signature Date \_\_\_\_\_

Provider Notes:

D.E.S. Notes:

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

Agency Name:

State Training Proportion of Total Trng. Cost [     %]

### CONTRACTED AGENCY QUARTERLY TRAINING REPORT (TRAINER & TRAINEE COSTS)

Staff Name (Last, First)	Position Title		Professional Degree (Ph.D., MSW, etc.)		Social Security or Position ID#			
Training Title/Topic and a Brief Description:	Trng. Purpose Categ*****	Training Dates	Training Modality*	Training Hours	Hourly Trng Cost**	Salary Cost***	Other Costs****	Total Trng. Cost
						\$ -		\$ -
						\$ -		\$ -
						\$ -		\$ -
						\$ -		\$ -
						\$ -		\$ -
<b>Total Training Hours/Cost for Staff</b>				0		\$ -	\$ -	\$ -

Staff Name (Last, First)	Position Title		Professional Degree (Ph.D., MSW, etc.)		Social Security or Position ID#			
Training Title/Topic and a Brief Description:	Trng. Purpose Categ*****	Training Dates	Training Modality*	Training Hours	Hourly Trng Cost**	Salary Cost***	Other Costs****	Total Trng. Cost
						\$ -		\$ -
						\$ -		\$ -
						\$ -		\$ -
						\$ -		\$ -
						\$ -		\$ -
<b>Total Training Hours/Cost for Staff</b>				0		\$ -	\$ -	\$ -

**INSTRUCTIONS:** 1) Read Attachment before filling out this form;

2) Use this form to list all training attended or conducted by staff.

**IV-E Training Form\_05**



# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT: Child Abuse and Neglect Check</b>	<b>Number:</b>	<b>80.406</b>
<b>REFERENCE:</b> Hawaii Revised Statutes 350; Hawaii Administrative Rules, Chapter 920.1-11-13	<b>APPROVED:</b>	
	<i>Signature on File</i>	1 Mar 2004
	Chief	Eff. Date

### PURPOSE

To establish procedures for child abuse and neglect clearances for the Child and Adolescent Mental Health Division (CAMHD) to ensure the safety of youths served by CAMHD employees or CAMHD's contracted agencies' staff.

### DEFINITIONS

*"Confirmed"* means a report of child abuse or neglect that has been investigated by the Department of Human (DHS) where there has been a determination by the DHS that physical, sexual, or psychological harm, physical neglect, threatened harm occurred, and a perpetrator of the harm or threat has been identified.

*"Child abuse or neglect"* means the acts or omissions of any person who, or legal entity which, is in any manner or degree related to the child, is residing with the child, or is otherwise responsible for the child's care, that have resulted in the physical or psychological health or welfare of the child, who is under the age of eighteen, to be harmed, or to be subject to any reasonably foreseeable, substantial risk of being harmed.

### POLICY

1. The CAMHD shall deny, revoke or not renew an individual provider's credentials and/or privileges, or certification to provide services to CAMHD youth if the individual has been confirmed as a perpetrator of harm or substantial risk of harm to a minor in a prior Child Abuse or Neglect (CAN) case involving any of the following:
  - A. Sexual abuse of all levels of harm at any time;
  - B. High or severe physical or psychological abuse at any time as defined by the DHS;
  - C. High or severe neglect (includes medical neglect, failure to thrive) at any time as defined by the DHS;
  - D. Involuntary termination of parental rights of a child due to neglect or abuse;
  - E. Moderate physical or psychological abuse within the last five (5) years, which may include repeated episodes of minor bruising, verbal humiliations and

REVISION HISTORY:  
Initial Effective Date:  
Biannual Review Date:

File Ref:  
A7010

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

SUBJECT: Child Abuse and Neglect Check	Number:	80.406

degradations, unexplained medical injuries which may or may not require medical assistance, and any other instance as defined by the DHS; or

- F. Moderate neglect within the last five (5) years, which may include: repeated episodes of impulsive and careless behaviors, failure to provide a safe and healthy environment, withholding of medical or necessary treatments, lack of appropriate supervision, and any other instance as defined by the DHS.
2. The CAMHD may deny, revoke or not renew an individual provider's credentials and/or privileges, or certification to provide services if the provider has been confirmed as a perpetrator in a CAN case *not listed above* if this could pose a risk to the health, safety or well-being of children under CAMHD's care.

### PROCEDURE

1. CAMHD and its contracted agencies will request, via a valid and signed informed consent to release information, a review of the DHS's *Child Protective Services System (CPSS)* registry for every direct service personnel according to procedure identified in CAMHD's Credentialing policies and procedures.
2. CAMHD's designated staff will review the DHS's *CPSS* registry for confirmed cases of CAN based on staff information provided by the contracted agency.
3. Designated CAMHD staff will consult with the DHS staff whenever the DHS's *CPSS* information is not available or is incomplete to determine cleared or confirmed cases of CAN.
4. Based on *CPSS* review and corroboration with the DHS staff, CAMHD's Credentialing Specialist or designee will inform the contracted agencies of those personnel that have been cleared.
5. CAMHD's Credentialing Specialist will notify contracted agencies or of employees with confirmed CAN histories as perpetrators involving criteria "a" through "f" of policy #1, or any other criteria deemed to be of high-risk by the Credentialing Committee, without divulging specifics relative to the nature of the history. Likewise, the Credentialing Specialist will inform the immediate clinical supervisor of any CAMHD staff with a confirmed CAN history.
6. Contract agencies will arrange for a copy of DHS' CAN report through the affected staff; interview the staff member, and request a letter from the staff that provides background information, follow-up actions taken, and any testimony self or otherwise, on his or her behalf.

REVISION HISTORY:  
Initial Effective Date:  
Biannual Review Date:

File Ref:  
A7010

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT: Child Abuse and Neglect Check</b>	<b>Number:</b>	<b>80.406</b>

7. The applicable contracted agency's or CAMHD's clinical supervisor or administrator of the specified staff will conduct a thorough assessment to determine the current level of risk involved, and subsequent course of action as future risk deterrents.
8. A written report of the risk assessment shall be sent to CAMHD's Credentialing Committee, with all supporting documents as necessary defining findings and justifying the course of action taken. Reports shall evidence assessments that consider at minimum, the following:
  - A. Type of harm,
  - B. When the harm occurred,
  - C. The circumstances surrounding the harm,
  - D. The frequency or pattern of occurrences,
  - E. Whether treatment or rehabilitation took place,
  - F. Degree of access to children and whether employment would pose a risk to children, and
  - G. Special conditions of continued employment, including degree and frequency of individual supervision.
9. The Credentialing Committee will:
  - A. Review agency's report of findings and actions;
  - B. Determine the relevancy and adequacy of all available information relative to actions taken regarding the employee;
  - C. If necessary, request additional information such as psychological evaluations, substance abuse assessments, *etc.*, with any costs incurred, the responsibility of the provider;
  - D. Recommend to the CAMHD Executive Management Team a course of action to be taken by CAMHD against an agency/provider if the seriousness of risk is established; and
  - E. Determine whether consideration may be given to the individual who shows more than a single evidence of being rehabilitated, which may include:
    - 1) Letters from a counselor or therapist indicating successful completion of treatment and a statement that the counselor believes the individual does not pose a risk to children;

REVISION HISTORY:  
Initial Effective Date:  
Biannual Review Date:

File Ref:  
A7010

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT: Child Abuse and Neglect Check</b>	<b>Number:</b>	<b>80.406</b>

- 2) Successful completion of past services that are relevant to the report of abuse or neglect;
  - 3) Statements from individuals who are credible and reliable who can document and verify a sustained change in the individual's behavior that is relevant to the individual's employment; or
  - 4) Positive conduct in the community or in employment.
10. The Credentialing Committee will inform the agency in writing, under CAMHD Chief's approval and signature, of CAMHD's decision, basis for the decision, and recommendations that may include:
  - A. Support of the individual's employment with evidence of rehabilitation;
  - B. Letters of support from past employers or community advocates that validates safety of the children;
  - C. Employee personnel record review via consent from the employer and employee; and
  - D. Re-evaluation of the employee in six (6) months, with a report of findings and actions submitted to CAMHD's Credentialing Committee.

**ATTACHMENT: None**

REVISION HISTORY:  
Initial Effective Date:  
Biannual Review Date:

File Ref:  
A7010

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT:</b> Re-credentialing of Licensed Health Care Professionals	<b>Number:</b>	<b>80.308.1</b>
<b>REFERENCE:</b> HRS; HI QUEST; QARI; HI State; 42 CFR; Licensing Boards; CMS; CAMHD QAIP; NCQA; HSAG Audit Tool	<b>APPROVED:</b>	
	<i>Signature on File</i>	02/22/05
	Chief	Eff. Date

### PURPOSE

To assure competent, safe, and effective practices by licensed qualified mental health professionals serving Child and Adolescent Mental Health Division (CAMHD) consumers.

### DEFINITIONS

See Glossary of Credentialing Terms (**See Attachment A**)

### POLICY

#### 1. Re-credentialing Policies

- A. Any State of Hawaii licensed practitioner considered by CAMHD as a QMHP that either, is employed with CAMHD, has an independent contract with CAMHD or is employed or subcontracted by a CAMHD Contracted Provider Agency, hereinafter referred to as CAMHD Agency, exclusive of hospital inpatient contracts, is covered under this policy.
- B. Re-credentialing of the following State of Hawaii Licensed practitioners are covered under this policy: Medical Doctor (M.D.), Licensed Social Worker (LSW), Licensed Marriage and Family Therapist (LMFT), Licensed Psychologist (Ph.D. or Psy.D.), Advanced Practice Registered Nurse (APRN), and Osteopathic Doctor (D.O.).
  1. Licensed Practitioners that do not need to be re-credentialed:
    - a. Practitioners who practice exclusively within the inpatient setting and who provide care for CAMHD consumers only as a result of the consumers being directed to the hospital or another inpatient setting. These practitioners need to be credentialed by the hospital or the inpatient setting they provide the services.
    - b. Practitioners who do not provide care for CAMHD consumers in a treatment setting (consultants).
- C. Criteria and Primary Source Verification used to satisfy criteria:
  1. State of Hawaii licenses must be primary source-verified with the State of Hawaii Department of Commerce and Consumer Affairs, Professional and

REVISION HISTORY: 8/13/02, 3/17/03  
Initial Effective Date: 2/15/02  
Biannual Review Date:

File Ref:  
A6800

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT:</b> Re-credentialing of Licensed Health Care Professionals	<b>Number:</b>	<b>80.308.1</b>
--	----------------	-----------------

2. Vocational Licensing Division (DCCA) at <http://www.ehawaii.gov/org/serv/pvl> to ensure that practitioners are licensed in the State of Hawaii.
3. Primary verification of CAMHD Credentialing requirements as outlined in the “CAMHD Licensed Provider Re-credentialing Checklist” must be satisfied by using acceptable verification methods within the specified timelines. **(See Attachment B)**

### D. Policies and Procedures

1. CAMHD shall use the following processes to determine re-credentialing decisions:
  - a. The CAMHD Credentialing Committee (Committee) shall evaluate the credentials of each applicant against pre-determined criteria in conjunction with National Commission of Quality Assurance (NCQA) and state licensing requirements.
  - b. The predetermined criteria listed in the “CAMHD Licensed Provider Re-credentialing Checklist” shall facilitate auditing of primary source verified documents in the practitioner’s credential chart.
  - c. The Committee members shall use their professional and personal knowledge of the applicant’s business practices, ethics, and ability to provide quality services to CAMHD consumers in a safe treatment environment in the decision making process.
2. Non-discrimination  
The Committee does not make credentialing decisions based on the applicant’s race, ethnic / national identity, gender, age, sexual orientation, or the types of procedures or types of patients the practitioner (e.g., Medicaid) specializes in.
3. The CAMHD shall notify the practitioner via regular mail of any information obtained during the credentialing process that varies substantially from the information provided to CAMHD and or to the CAMHD Agency by the practitioner.
  - a. The applicant must respond within fifteen (15) business days from the date of receipt of the notification letter with a letter of explanation explaining the discrepancy or variance. Additional

REVISION HISTORY: 8/13/02, 3/17/03  
Initial Effective Date: 2/15/02  
Biannual Review Date:

File Ref:  
A6800

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT:</b> Re-credentialing of Licensed Health Care Professionals	<b>Number:</b>	<b>80.308.1</b>
--	----------------	-----------------

documents may be submitted to CAMHD or to the CAMHD Agency to substantiate or explain the variations.

- b. CAMHD has fifteen (15) business days from the date of receipt of the applicant's letter of explanation to review documents and render a decision. The decision letter includes the reconsideration and appeal process stated below.

#### 4. *The Request for Reconsideration & Appeal Process*

- a. If an applicant does not agree with the Committee's decision, he/she may request a re-consideration.
- b. Re-consideration requests must be submitted with additional documentation of new information to support the request.
- c. The applicant must submit any additional documents to CAMHD within fifteen (15) business days from the decision letter, unless otherwise stated.
- d. The Committee will review the submitted documents and issue a reconsideration decision to the applicant or through the Agency via facsimile or mail within fifteen (15) business days from the date of receipt of the reconsideration request.
- e. The applicant, either directly or through the CAMHD Agency, has the option to file a formal complaint with CAMHD's Grievance Office (GO) at 733-8495 in the event the Committee holds to its original decision.

#### 5. The process to ensure that notified applicants have the credentialing or re-credentialing decision within sixty (60) calendar days of the Committee's decision.

- a. A Committee *letter of decision* shall be sent to the applicant through the CAMHD Agency within fifteen (15) business days of the decision.
- b. If the applicant does not agree with the decision he/she is entitled to request for reconsideration through the "*Request for Reconsideration & Appeal Process*" outlined above.

#### 6. The medical director or other designated health care professional's direct responsibility and participation in the CAMHD credentialing program:

REVISION HISTORY: 8/13/02, 3/17/03  
Initial Effective Date: 2/15/02  
Biannual Review Date:

File Ref:  
A6800

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT:</b> Re-credentialing of Licensed Health Care Professionals	<b>Number:</b>	<b>80.308.1</b>
--	----------------	-----------------

- a. The Committee Chairman, a Clinical Director from one of CAMHD's Family Guidance Centers (FGC), has direct oversight of the CAMHD Credentialing program.
  - b. His primary role shall be to ensure that the committee functions within its defined role, evaluates its projected goals through committee-approved performance measures, as well as to report the committee's activities and accomplishments to the CAMHD Performance Improvement Steering Committee (PISC).
  - c. The CAMHD Medical Director sits on the Committee as an ex-officio member to provide guidance and feedback to the committee.
7. The process used to ensure confidentiality of all information obtained in the re-credentialing process, except otherwise provided by law.
  - a. The Committee and CAMHD Agencies' Credentialing Specialists and other personnel that have access to credential information must sign the "*CAMHD Credentialing Committee Member Confidentiality Form*" to ensure confidentiality of all information gathered during the re-credentialing process, except otherwise provided by law, used for the sole purpose of credentials evaluation. **(See Attachment C)**
  - b. In addition, any discussions held during the Committee shall remain confidential except when otherwise provided by law.
8. The process to delegate re-credentialing:
  - a. The primary source verification portion of the re-credentialing process is delegated to the Agency for their employees and subcontractors.
  - b. This function is delegated to a contracted credentialing verification service for CAMHD employees and contractors.
  - c. Refer to the "*CAMHD Credentialing Delegation Policies and Procedures*" for specific delegated activities and CAMHD monitoring of those activities.

### E. Practitioner Rights

1. The practitioner has the right to review submitted information in support of his/her credentialing application. The following statement is included in

REVISION HISTORY: 8/13/02, 3/17/03  
Initial Effective Date: 2/15/02  
Biannual Review Date:

File Ref:  
A6800



## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT:</b> Re-credentialing of Licensed Health Care Professionals	<b>Number:</b>	<b>80.308.1</b>
--	----------------	-----------------

the “*Licensed Provider Re-credentialing Application Form*” (See **Attachment D**) to notify the applicant of this right:

- a. The applicant has the right to request and review primary source verifications obtained on their behalf. A written request must be sent to the CAMHD Credentialing Specialist, CAMHD Credentialing Unit, 3627 Kilauea Avenue, Room 101, Honolulu, Hawaii 96816.
  - b. The CAMHD Credentialing Specialist has thirty (30) days to forward copies of primary source documents to the applicant via regular mail. In the event that the primary source verification function has been delegated to the Agency, the written request must be sent to the attention of the Agency Credentialing Specialist.
  - c. The CAMHD Credentialing Specialist has thirty (30) days to forward the copies of the primary source documents to the applicant via regular mail.
2. The practitioner has the right to correct erroneous information.
- a. In the event that credentialing information obtained from other sources varies substantially from that provided by the applicant, CAMHD must notify the applicant in writing within fifteen (15) business days from date of discovery. Notification may be sent directly to the applicant or through the CAMHD Agency Credentialing Specialist.
  - b. The applicant has the right to correct erroneous information by sending a letter directly to the Committee to the following address: CAMHD Credentialing Specialist, CAMHD Credentialing Unit, 3627 Kilauea Avenue, Room 101, Honolulu, HI 96816 or through the CAMHD Agency in writing within 15 business days from date of receipt of the notification letter from CAMHD. Additional documents may be submitted to CAMHD and or its Agency to substantiate or explain the erroneous information.
  - c. CAMHD has thirty (30) days from the date of receipt of the letter of explanation to review documents and render a decision. The decision letter includes the reconsideration and appeal process stated in the “*Request for Reconsideration & Appeal Process*” section of this policy.

REVISION HISTORY: 8/13/02, 3/17/03  
Initial Effective Date: 2/15/02  
Biannual Review Date:

File Ref:  
A6800

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT:</b> Re-credentialing of Licensed Health Care Professionals	<b>Number:</b>	<b>80.308.1</b>
--	----------------	-----------------

3. The practitioner has the right, upon request, to be informed of the status of his/her credentialing or recredentialing application.
  - a. The applicant has the right to request, in writing or through telephone, the status of his/her credentialing or recredentialing application. The CAMHD Credentialing Specialist must respond to such inquiry within ten (10) business days either in writing or through telephone.
  - b. The applicant may not review peer-review protected information, references, and letters or recommendations.
  - c. Notification of practitioner's rights shall be included in the credentialing application form.

### 2. Credentialing Committee

#### A. The Credentialing Committee

The standing Child and Adolescent Mental Health Division (CAMHD) credentialing committee is designated to provide oversight over CAMHD's credentialing processes. Membership shall be representative of various disciplines from CAMHD's various sections with preference given, but not limited to licensed professionals. Membership for the CAMHD Credentialing Committee is outlined in the CAMHD Credentialing Committee Membership Policies and Procedures.

#### B. Credentialing Committee Decisions

1. The Committee may grant authority to the CAMHD Credentialing Specialist to conduct a preliminary review of each practitioner's credentials in accordance with the "CAMHD *Licensed Provider Re-credentialing Checklist*" to ensure all primary source verifications being submitted meet CAMHD's established criteria. The CAMHD Credentialing Specialist shall:
  - a. Make available applicant files that meet established criteria at the Credentialing Unit office for the Committee members to review prior to the scheduled meetings.
  - b. Submit the list of the applicants who meet the established criteria at the next Committee meeting.

REVISION HISTORY: 8/13/02, 3/17/03  
Initial Effective Date: 2/15/02  
Biannual Review Date:

File Ref:  
A6800

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT:</b> Re-credentialing of Licensed Health Care Professionals	<b>Number:</b>	<b>80.308.1</b>
--	----------------	-----------------

2. If re-credentialing did not occur prior to the expiration of the initial credentialing date the practitioner may not see consumers until the date of final approval from the Committee.
3. CAMHD reserves the right to make the final determination about which practitioners may participate in its network. If unfavorable information is obtained about a practitioner during the credentialing process, CAMHD reserves the right to ask for additional information and render a decision to approve the practitioner with or without restrictions or to disapprove the practitioner with reasons as discussed during the Committee meeting. The *decision letter* shall include the reconsideration and appeal process as stated in the “*Request for Reconsideration & Appeal Process*” section of this policy.
4. The applicant will be notified either directly or through the Agency of the deficiencies and corrective action requested through regular or electronic mail. The response deadline shall be included in the *decision letter*.
5. The Committee has thirty (30) days from the date of receipt of the *letter of explanation* to review documents and render a decision. The *decision letter* includes the rationale for the decision and the reconsideration and appeal process stated in the “*Request for Reconsideration & Appeal Process*” section of this policy.

### 3. Re-credentialing

#### A. Method of Verification

1. CAMHD or its Agencies may use oral, written, and Internet website data to verify information. Oral verifications require a note stating the date of verification, the name of the person from the primary source who verified the information, the name and dated signature of the CAMHD or the CAMHD Agency staff that verified the information.
2. Internet website verification requires the dated signature of the CAMHD or its Agency staff that conducted the query on all printed pages. Written verifications may take the form of a letter that is received via regular mail or facsimile.

#### B. Verification Time Limit

To prevent the Committee from considering a practitioner whose credentials may have changed since they were last verified, primary source verification must be no more than 180 days old (unless otherwise stated) at the time of the credentialing

REVISION HISTORY: 8/13/02, 3/17/03  
Initial Effective Date: 2/15/02  
Biannual Review Date:

File Ref:  
A6800

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT:</b> Re-credentialing of Licensed Health Care Professionals	<b>Number:</b>	<b>80.308.1</b>
--	----------------	-----------------

committee decision. For written verifications, the 180-day time limit begins with the date that the credentials were verified (the date on the letter or the signature date) not when CAMHD or the Agency received the information.

### C. Re-credentialing Cycle

1. Upon approval of re-credentialing, the two (2)-year full approval cycle begins. Practitioners are considered re-credentialed after the committee has made its decision. Once a practitioner is re-credentialed, they are able to carry their full re-credentialed status for all CAMHD Agencies. They are not required to be re-credentialed every time they change employment as long as it occurs within the two year approved timeframe. There are requirements for interagency credential status transfer. Refer to the Interagency Transfer section of this policy for those requirements.

### D. Practitioner Suspension of Participation

The CAMHD Credentialing Committee has the authority to recommend suspension of a practitioner's participation in providing services to CAMHD youths to CAMHD's Executive Management Team (CAMHD EMT). Suspension during investigation is an immediate consideration in cases where potential risk or harm exists to CAMHD clients by the practitioner. These risks are determined from preliminary reports to the CAMHD Credentialing Committee from any of the following:

- Sentinel Events Unit
- Grievance Office
- Performance Monitoring Unit
- Facility Certification Unit
- Possible abuse as indicated in the CAN Check Results

The Performance Management Section or CAMHD designee(s), shall immediately determine, per Level I criteria, if the allegation warrants a joint Provider/CAMHD investigative inquiry.

#### Level I Criteria:

- a. One (1) allegation of sexual abuse of a client
- b. One (1) allegation of physical abuse of a client
- c. One (1) allegation of substandard, inappropriate or harmful services

REVISION HISTORY: 8/13/02, 3/17/03  
Initial Effective Date: 2/15/02  
Biannual Review Date:

File Ref:  
A6800

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT:</b> Re-credentialing of Licensed Health Care Professionals	<b>Number:</b>	<b>80.308.1</b>
--	----------------	-----------------

- d. Two (2) corroborated and/or three (3) uncorroborated allegation of verbal abuse of a client
- e. One (1) report of a client injured by a staff member during a seclusion or restraint
- f. Two (2) reports within a three-month period of time of a medication error
- g. Four (4) reports within a six-month period of time of a medication error
- h. Breach of the Interagency Performance Standards and Practice Guidelines in providing required
  - Access
  - Assessments
  - Service Plans
  - Supervision and training
  - Records
  - Service quality
  - Reporting
  - Management of risk and safety for consumers as described in the IPSPGs, including mandated reporting for child abuse and neglect
  - Community focus as described in the IPSPGs
  - Adherence to general professional practice, State of Hawaii statutes and licensing requirements Consumer rights and confidentiality

If Level I criteria are met, the Credentialing Committee shall be asked to formally request that the CAMHD EMT impose an immediate 30-day maximum suspension of practitioner credentials resulting in removal of practitioner from direct youth services pending the outcome of the investigation.

A joint investigative probe shall consist of up to three (3) persons representing the Child and Adolescent Mental Health Division and up to three (3) persons representing the contracted provider agency. The investigation shall follow established procedures set forth by the CAMHD Safety and Risk Management Policies and Procedures.

REVISION HISTORY: 8/13/02, 3/17/03  
Initial Effective Date: 2/15/02  
Biannual Review Date:

File Ref:  
A6800

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT:</b> Re-credentialing of Licensed Health Care Professionals	<b>Number:</b>	<b>80.308.1</b>
--	----------------	-----------------

As a result of a CAMHD investigation a Limitation or Reduction of a practitioner's participation may include, but is not limited to any of the following:

- The number of credentialed days to quarterly increments depending on severity of issues involved.
- The number of agencies a practitioner would be eligible to work for.
- The number of hours a practitioner would be able to work.
- The number of employees a licensed practitioner may be able to supervise.
- The type of CAMHD clients a certain practitioner may be eligible to work with.
- The type of function a certain practitioner may be eligible to perform.
- Other related limitations and restrictions determined on an individualized basis.

The CAMHD Credentialing Committee makes a final recommendation to the CAMHD EMT regarding the practitioner's participation with CAMHD.

The CAMHD EMT's decision letter is issued within five (5) working days of the decision.

The decision from the CAMHD EMT letter includes the reconsideration and appeal process stated in the *"Request for Reconsideration & Appeal Process"* section of this policy.

### E. Reduction or Limitation of Participation

1. The CAMHD Credentialing Committee has the authority to recommend limitation or restriction of a practitioner's participation in the CAMHD Provider Network to the CAMHD EMT. Limitation and restriction may be considered in any of the following cases:

- Previous Grievance, Sentinel Events, or Performance Monitoring report involving any of the events outlined in the Level 1 Criteria while previously employed with another CAMHD Contracted agency.
- Previous Criminal Record within the past 10 years
- Reported Prior Termination due to poor performance

REVISION HISTORY: 8/13/02, 3/17/03  
Initial Effective Date: 2/15/02  
Biannual Review Date:

File Ref:  
A6800

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT:</b> Re-credentialing of Licensed Health Care Professionals	<b>Number:</b>	<b>80.308.1</b>
--	----------------	-----------------

- Prior Malpractice Claims within the past 10 years
  - Positive CAN Check Results within the past 10 years
  - Prior Drug Abuse Record within the past 10 years
2. As a result of a CAMHD investigation Limitation or Reduction of a practitioner's participation may include, but is not limited to any of the following:
- The number of credentialed days to quarterly increments depending on severity of issues involved.
  - The number of agencies a practitioner would be eligible to work for.
  - The number of hours a practitioner would be able to work.
  - The number of employees a licensed practitioner may be able to supervise.
  - The type of CAMHD clients a certain practitioner may be eligible to work with.
  - The type of function a certain practitioner may be eligible to perform.
  - Other related limitations and restrictions determined on an individualized basis.

The CAMHD Credentialing Committee reviews the facts and makes a final recommendation to the CAMHD EMT regarding the practitioner's participation with CAMHD.

The CAMHD EMT's decision letter is issued within five (5) working days of the decision.

The decision from the CAMHD EMT letter includes the reconsideration and appeal process stated in the "*Request for Reconsideration & Appeal Process*" section of this policy.

### F. Practitioner Termination

1. The CAMHD Credentialing Committee has the authority to recommend termination of a practitioner's participation in the CAMHD Provider Network to the CAMHD EMT. Termination may be considered in any of the following cases:

REVISION HISTORY: 8/13/02, 3/17/03  
Initial Effective Date: 2/15/02  
Biannual Review Date:

File Ref:  
A6800

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT:</b> Re-credentialing of Licensed Health Care Professionals	<b>Number:</b>	<b>80.308.1</b>
--	----------------	-----------------

- Loss of License
- Exclusion from the Medicare / Medicaid program
- Misrepresentation of credentials and / or other pertinent information
- Involvement in a malpractice claim that involves client safety
- Criminal indictment of any type
- Failure to adhere to established as part of the suspension investigations and reduction or limitation of participation investigations.

1. The CAMHD Credentialing Committee reviews the facts and makes a final recommendation to the CAMHD EMT regarding the practitioner's participation with CAMHD.
2. The CAMHD EMT's decision letter is issued within five (5) working days of the decision.
3. The decision from the CAMHD EMT letter includes the reconsideration and appeal process stated in the "*Request for Reconsideration & Appeal Process*" section of this policy.

### G. Practitioner Reinstatement

1. If a CAMHD or CAMHD Contract Agency employee or subcontractor is voluntary or involuntarily terminated and the practitioner wishes to be reinstated, the practitioner must again be initially credentialed if the break in service is *thirty (30) calendar days* or more. CAMHD and/or the CAMHD Contract Agency must re-verify credential factors that are no longer within the credentialing time limits. The CAMHD Credentialing Committee must review all credentials and makes a final determination prior to the practitioner's re-entry into the organization. The CAMHD Credentialing Committee makes a final determination prior to the practitioner's re-entry into the organization and issues a decision letter within five (5) working days of its decision. The decision letter includes the reconsideration and appeal process stated in the "*Request for Reconsideration & Appeal Process*" section of this policy.
2. An interagency transfer is allowed after termination provided it is within thirty (30) calendar days of the termination date and there are no negative incidents that led to the termination from the previous CAMHD Contract

REVISION HISTORY: 8/13/02, 3/17/03  
Initial Effective Date: 2/15/02  
Biannual Review Date:

File Ref:  
A6800



# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT:</b> Re-credentialing of Licensed Health Care Professionals	<b>Number:</b>	<b>80.308.1</b>
--	----------------	-----------------

Agency. The CAMHD Credentialing Committee must review presented facts and makes a final determination prior to the practitioner's re-entry into the organization.

If prior termination was due to negative incidents, the CAMHD or CAMHD Contract Agency employee or subcontractor must submit a written statement of explanation with the interagency transfer request or re-application request. The CAMHD Credentialing Committee must review all facts related to the negative discharge including performance of the CAMHD or CAMHD Contract Agency employee or subcontractor while employed or subcontracted with CAMHD or the CAMHD Contract Agency. The CAMHD Credentialing Committee makes a final determination which may include imposing limitations and restrictions on the practitioner's participation with CAMHD prior to the practitioner's re-entry into the organization and issues a decision letter within five (5) working days of its decision. The decision letter includes the reconsideration and appeal process stated in the "*Request for Reconsideration & Appeal Process*" section of this policy.

### H. CAMHD Network Participation Requirements

To be eligible to become a member of the CAMHD Provider Network, the applicant must be an employee or direct contractor of CAMHD or an employee or subcontractor of an Agency.

### I. Re-credentialing Documents and Primary Source Verification Requirements

The "*CAMHD Licensed Provider Re-credentialing Checklist*" outlines the CAMHD required primary source verifications, verification timeline requirements, and methods of accepted primary source verification including the following criteria items:

1. Attestation Letter (**See Attachment E**)  
*Verification time limit: 180 days*  
The Agency or CAMHD designated primary source verification agency representative must complete the "*CAMHD Attestation Letter*".
2. License Number

REVISION HISTORY: 8/13/02, 3/17/03  
Initial Effective Date: 2/15/02  
Biannual Review Date:

File Ref:  
A6800

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT:</b> Re-credentialing of Licensed Health Care Professionals	<b>Number:</b>	<b>80.308.1</b>
--	----------------	-----------------

The practitioner's license number must be entered in the CAMHD "Licensed Provider Initial Re-credentialing Checklist." Verification of the license is done in the license verification portion of the policy.

3. Application Form  
*Verification time limit: 180 days*

All sections of the "CAMHD Licensed Provider Re-credentialing Application Form" must be completed. Work History information may be listed in the resume in lieu of the application form. The application form must include the following items:

- a. Reasons for inability to perform the essential functions of the position, with or without accommodation.

*Verification time limit: Attestation on application must be signed no earlier than 180 days prior to Committee approval.*

CAMHD and its Agency must ensure that the following question in the credentialing application form contains a "No" answer:

*Do you have any physical and/or mental condition which would interfere with the performance of those privileges which you are requesting and/or the essential functions of the contractual arrangement for which you are applying, with or without accommodation?*

In the event an applicant answers "Yes" a *letter of explanation* must accompany the application. The Committee must review the letter of explanation and weigh the implications of any health conditions stated as it pertains to the applicant's ability to perform the functions of the position that the practitioner is being credentialed for. The Committee may consider approval of the applicant with or without restrictions.

- b. Lack of present illegal drug use.

*Verification time limit: Attestation on application must be signed no earlier than 180 days prior to Committee approval.*

CAMHD and its Agency must ensure that the restrictive actions questions pertaining to illegal drug use in the credentialing application form contains a "No" answer.

REVISION HISTORY: 8/13/02, 3/17/03  
Initial Effective Date: 2/15/02  
Biannual Review Date:

File Ref:  
A6800

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT:</b> Re-credentialing of Licensed Health Care Professionals	<b>Number:</b>	<b>80.308.1</b>
--	----------------	-----------------

In the event an applicant answers “Yes” a letter of explanation must accompany the application. The Committee must review the letter of explanation and weigh the implications of any illegal drug use reported as it pertains to the applicant’s ability to perform the functions of the position that the applicant is being credentialed for.

- c. History of loss of license and felony convictions.

Verification time limit: Attestation on application must be signed no earlier than 180 days prior to Committee approval.

CAMHD and its Agency must ensure that the restrictive actions questions pertaining to loss of license and felony convictions in the credentialing application form contains a “No” answer. In addition, the Hawaii Justice Center Check results would also be considered to satisfy the felony conviction verification requirements of this criterion.

In the event an applicant answers “Yes” a letter of explanation must accompany the application. The Committee must review the letter of explanation and weigh the implications of any loss of license and or felony convictions it relates to the applicant’s ability to perform the functions of the position that the applicant is being credentialed for.

- d. History of loss or limitation of privileges or disciplinary activity.

*Verification time limit: Attestation on application must be signed no earlier than 180 days prior to Committee approval.*

CAMHD and its Agency must ensure that the restrictive actions questions pertaining to limitation of privileges or disciplinary actions in the credentialing application form contains a “No” answer.

In the event an applicant answers “Yes” a *letter of explanation* from the applicant must accompany the application. The Committee must review the *letter of explanation* and weigh the implications of any loss or limitation of privileges or disciplinary activity it relates to the applicant’s ability to perform the functions of the position that the applicant is being credentialed for. The Committee reserves the right to ask for a letter from the applicant’s

REVISION HISTORY: 8/13/02, 3/17/03  
Initial Effective Date: 2/15/02  
Biannual Review Date:

File Ref:  
A6800

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT:</b> Re-credentialing of Licensed Health Care Professionals	<b>Number:</b>	<b>80.308.1</b>
--	----------------	-----------------

supervisor and or Agency to ensure that proper mechanisms are in place to prevent a similar situation from occurring while practitioner is serving CAMHD consumers.

- e. Attestation as to the correctness and completeness of the application.  
*Verification time limit: Attestation on application must be signed no earlier than 180 days prior to Committee approval.*  
The applicant must sign and date the following attestation statement in the application:

*“I represent that information provided in or attached to this credentialing application form is accurate. I understand that a condition of this application is that any misrepresentation, misstatement or omission from this application, whether intentional or not, is cause for automatic and immediate rejection of this application and may result in the denial of appointment and clinical privileges. In the event of my termination for this reason, I will not be entitled to any hearing, appeal, or other due process rights. Upon subsequent discovery of such misrepresentation, misstatement, or omission, the <NAME OF AGENCY> may immediately terminate my appointment.”*

4. Resume  
Verification time limit: 180 days  
CAMHD does not require primary source verification of work history. A minimum of five (5) years of work history must be obtained through the practitioner’s application or curriculum vitae. If it is obtained from the resume, the resume must state a date of preparation so that the Committee is able to determine the 180-day time limit for this criterion. The applicant must submit a written explanation of any gaps over 6 months.
5. Education, Residency, Internship, Fellowship, Board Certification if obtained higher education since last credentialed.
- a. Education and training including board certification if the practitioner states on the application that he/she is board certified.
- b. *Verification time limit: None. This means that old verifications would be considered acceptable provided it verifies the education*

REVISION HISTORY: 8/13/02, 3/17/03  
Initial Effective Date: 2/15/02  
Biannual Review Date:

File Ref:  
A6800

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT:</b> Re-credentialing of Licensed Health Care Professionals	<b>Number:</b>	<b>80.308.1</b>
--	----------------	-----------------

*that is applicable to the licensure the applicant is being credentialed for.*

CAMHD or its Agency must verify *only the highest level* of credentials attained. If a physician is board certified, verification of that board certification fully meets this element, because specialty boards verify education and training. For practitioners, who are not board certified, verification of completion of residency fully meets this requirement. For those who have not completed a residency program, verification of graduation from medical school meets this standard.

c. Education Verification Requirements for Different Specialties:

*For Board Certified Physicians:*

Verification of board certification fully meets education verification requirements because medical boards already verify education and training. Separate verification of education and residency training is not required for board certified medical doctors.

For Non-Board Certified Physicians:

Conduct verification by doing one of the following:

Verification of completion of residency training meets this requirement through any of the following primary source verification methods:

- Confirmation from the residency-training program.
- Entry in the American Medical Association (AMA) Physician Master File.
- Entry in the American Osteopathic Association (AOA) Physician Master File.

Verification of graduation from medical school through any of the following primary source verification methods:

- Confirmation from the medical school.
- Entry in the American Medical Association (AMA) Physician Master File.

REVISION HISTORY: 8/13/02, 3/17/03  
Initial Effective Date: 2/15/02  
Biannual Review Date:

File Ref:  
A6800

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT:</b> Re-credentialing of Licensed Health Care Professionals	<b>Number:</b>	<b>80.308.1</b>
--	----------------	-----------------

- Entry in the American Osteopathic Association (AOA) Physician Master File.
- Confirmation from the Educational Commission for Foreign Medical Graduates (ECFMG) for international medical graduates after 1986.

### Non-Physician Behavioral Healthcare Professionals

Confirmation from the university specifically stating name of applicant, degree and date conferred. Written verifications must be received directly from the university attended. Telephone verifications are acceptable provided the name of the person verifying the information; the date of verification, and the person's name at the primary source is identified in a memo.

- c. Board certification, if designated by the practitioner on the application.
- d. *Verification Time Limit: Any NCQA recognized source is valid up to one year but if it is a document source (e.g. ABMS Compendium), verification must also be based on the most current edition.*

If an applicant states in their application form that they are board-certified, the board certification must be queried. Acceptable methods of verification includes any of the following:

### Physicians

Completion of one of these:

- Entry in the ABMS Compendium.
- Entry in the AOA Physician Master File.
- Entry in the AOA Directory of Osteopathic Physicians.
- Entry in the AMA Master File.
- Confirmation from the specialty board

### Non-Physician Behavioral Healthcare Professionals

Confirmation from the specialty board.

REVISION HISTORY: 8/13/02, 3/17/03  
Initial Effective Date: 2/15/02  
Biannual Review Date:

File Ref:  
A6800

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT:</b> Re-credentialing of Licensed Health Care Professionals	<b>Number:</b>	<b>80.308.1</b>
--	----------------	-----------------

### *Foreign Trained Physicians*

Foreign trained physicians who graduated and obtained license after 1986 must submit a copy of their ECFMG certificate.

### 6. Controlled Substance Certificates

*Verification time limit: Certificate must be effective at the time of the credentialing committee decision.*

If the applicant is a medical doctor, a copy of the current DEA and state NED certificate must be present at the time of credentialing approval.

A practitioner with a pending DEA application may be credentialed provided that another practitioner with a valid DEA certificate write all prescriptions requiring a DEA number for the practitioner until the practitioner has a valid DEA certificate. The name of the practitioner with the valid DEA number must be noted clearly on the credentialing file of the practitioner without a DEA number.

### 1. Malpractice Insurance

#### a. Current malpractice insurance coverage.

*Verification time limit: Coverage must be effective at the time of the credentialing decision.*

CAMHD and / or its Agency must obtain a letter confirming current malpractice coverage from the insurer. The letter must state the name of the practitioner, policy number, dates of coverage, and 1 million/3 million aggregate of coverage. Copies of face sheets from the practitioner will not satisfy this requirement unless it has been received from the insurer.

#### b. History of professional liability claims that resulted in settlements or judgments paid by or on behalf of the practitioner.

*Verification time limit: 180 days*

CAMHD or its Agency must obtain written confirmation of malpractice settlements from the current malpractice carrier and for all malpractice carriers since last credentialed. These years may include residency years. In some instances, practitioners may have been covered by a hospital insurance policy during residency. In these cases, CAMHD or its Agency does not need to obtain confirmation from the carrier.

REVISION HISTORY: 8/13/02, 3/17/03  
Initial Effective Date: 2/15/02  
Biannual Review Date:

File Ref:  
A6800

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT:</b> Re-credentialing of Licensed Health Care Professionals	<b>Number:</b>	<b>80.308.1</b>
--	----------------	-----------------

7. State of Hawaii License Verification

Verification time limit: 180 days

CAMHD must confirm that the applicant holds a valid, current State of Hawaii licensure to practice. The license must be primary source verified with the State of Hawaii DCCA, Professional and Vocational Licensing Division at <http://www.ehawaii.gov/org/serv/pvl>. A printout of the license must be completed. The person conducting the query must date and sign all the pages of the printout results.

8. State sanctions, restrictions on licensure and or limitation on scope of practice.

The practitioner's license limitations and restrictions must be primary source verified with the State of Hawaii Department of Commerce and Consumer Affairs, Professional and Vocational Licensing Division at <http://www.ehawaii.gov/org/serv/pvl>. A printout of the complaints history must be completed. The person conducting the query must date and sign all the pages of the printout results.

9. Medicare / Medicaid Sanctions

Verification time limit: 180 days

The Office of the Inspector General at <http://exclusions.oig.hhs.gov/search.html> must be queried for the existence of any Medicare / Medicaid sanctions against the applicant. A printout of the results must be done. The person conducting the query must initial all printout results. The query results must indicate "no records" query result. In the event that there is a record on file, the applicant must provide a letter of explanation of the record. The committee will review the implications of the record as it pertains to the applicant's ability to provide quality services to CAMHD consumers.

10. Hawaii Justice Center Data Bank Verification:

Verification time limit: 180 days

The Hawaii Justice Center Data Bank must be queried for any criminal record. The query results must indicate "no records found". In the event that a record is found within the past ten (10) years, the applicant must provide CAMHD a written explanation of the record. Rehabilitative or self-improvement programs attended to help improve whatever issues there may be at the time of offense should be listed. In addition, the

REVISION HISTORY: 8/13/02, 3/17/03  
Initial Effective Date: 2/15/02  
Biannual Review Date:

File Ref:  
A6800



# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT:</b> Re-credentialing of Licensed Health Care Professionals	<b>Number:</b>	<b>80.308.1</b>
--	----------------	-----------------

Agency must also submit to CAMHD a written supervision plan that outlines the position and overall function of the applicant, supervision structure, and any other mechanisms in place to prevent similar offenses from occurring while the applicant is employed with the Agency or around CAMHD consumers. Traffic violations that are not alcohol related do not need a letter of explanation provided that the practitioner does not drive CAMHD consumers.

### 11. National Practitioner Data Bank Query

Verification time limit: 180 days

The National Practitioner Data Bank (NPDB) must be queried for previous malpractice claims history and or state licensure sanctions. CAMHD or its delegated primary source verification contractor and or the Agency must become registered users of the NPDB to be able to request verifications. The query results must indicate “*no records found*” query result. In the event that there is a record on file, the applicant must provide a letter of explanation of the record. The committee will review the implications of the record as it pertains to the applicant’s ability to provide quality services to CAMHD consumers.

### 12. Child and Abuse Neglect Verification.

Verification time limit: 180 days

The Department of Human Services Child Protective Services Database shall be queried for child abuse and neglect records. The “*CAMHD CAN Request Form*” (**See Attachment F**) and “*CAMHD CAN Authorization Form*” must be completed. (**See Attachments G**) The query results must indicate “no records found”. In the event that a record is found, CAMHD must notify the applicant or the Agency of the record. Please refer to the generic “*CAMHD CAN Negative Result Check Generic Letter*” format. (**See Attachment H**)

## 4. Re-credentialing Site Visits

Time Limit: Onsite audit conducted within one year of credentialing approval.

Onsite visits shall be conducted on an annual basis for all practitioner sites. These sites shall include treatment offices located within CAMHD including Family Guidance Centers, or CAMHD Contract Agency Headquarters, community treatment offices, residential facilities, and any other locations as reported by the practitioner applicant. The

REVISION HISTORY: 8/13/02, 3/17/03  
Initial Effective Date: 2/15/02  
Biannual Review Date:

File Ref:  
A6800

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT:</b> Re-credentialing of Licensed Health Care Professionals	<b>Number:</b>	<b>80.308.1</b>
--	----------------	-----------------

CAMHD Treatment Office Site Visit Tool will be used for these treatment office site visits. (See Attachment I)

### A. Performance Standards and Thresholds

1. Treatment Office Evaluation  
The “*Treatment Office Visit Tool*” shall be used for this review. A designated CAMHD staff will conduct the on-site visit. A minimum score of 80% for the office site section is required. For practitioners providing services in a Special Treatment Facility (STF) or Therapeutic Group Home (TGH), the license to operate issued by the OHCA will be accepted as verification that the facility is in compliance with all state laws pertaining to the type of service.
2. Treatment Record-keeping Practices  
The “*Treatment Office Visit Tool*” shall be used for this review. A designated CAMHD staff will conduct the onsite visit. A minimum score of 80% for the office site section is required.
3. Medication Storage and Log Requirements  
The “*Treatment Office Visit Tool*” shall be used for this review. A designated CAMHD staff will conduct the onsite visit. A minimum score of 80% for the office site section is required.
4. Availability of Emergency Equipment  
The “*Treatment Office Visit Tool*” shall be used for this review. A designated CAMHD staff will conduct the onsite visit since. A minimum score of 80% for the office site section is required.
5. Identification of high volume practitioners  
All practitioners in the CAMHD network are subject to all the rules set forth in this policy regardless of the volume of CAMHD consumers they treat. Information from the utilization management threshold outliers will be reviewed during re-credentialing.
6. Follow-Up Actions for Annual On-site Visit Findings / Deficiencies  
Reporting of Annual On-site Audit Deficiencies and Corrective Action Activities

If the practitioner scores lower than 80% on any of the criteria in the “*Treatment Office Visit Tool*” during the initial visit, the CAMHD staff conducting the visit will request a corrective action

REVISION HISTORY: 8/13/02, 3/17/03  
Initial Effective Date: 2/15/02  
Biannual Review Date:

File Ref:  
A6800

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT:</b> Re-credentialing of Licensed Health Care Professionals	<b>Number:</b>	<b>80.308.1</b>
--	----------------	-----------------

plan from the practitioner through the Agency during the exit interview. A written notification will also be sent to the practitioner through the Agency via regular mail or electronic mail. Credentialing of the practitioner will be deferred until all deficiencies in the onsite visit are addressed and a score of 80% or higher is obtained. Corrective action plans or other required documents must be submitted to the CAMHD Credentialing Specialist no later than thirty (30) days from the date of onsite visit. CAMHD will review the corrective action plan and submitted documents. All primary source verifications in the deferred file must be within acceptable timelines at the time of review and approval by the Committee.

### 7. Follow-up On-site Visit

- a. CAMHD reserves the right to conduct a follow up onsite visit prior to approving the practitioner to ensure that deficiencies noted are now within acceptable thresholds.

### 8. Performance Monitoring and Sanctions

- a. State sanctions or limitations on licensure

On a yearly basis, at the time of provider network reporting to the Med-QUEST Division, the status of practitioner's State of Hawaii licensure, sanctions, or limitations thereof are verified. In addition, CAMHD compiles all listing of Medicaid suspended or terminated practitioner's letters from the Med-Quest Division. In the event that the name being reported by Medicaid is a current member of the CAMHD provider network, the issue will be brought to the Committee within 24 hours of receipt to conduct an emergency meeting to formalize the suspension or termination of the practitioner from the network.

- b. Grievance Office Information

The Grievance Office must be queried for any substantiated complaints against a practitioner since the last credentialing date. "*No complaints*" query results must be noted in the practitioner's credential file. If there is a complaint, the CAMHD Credentialing Unit must request a copy of the Grievance Office letter of findings. This must be included in the practitioner's credential file and taken

REVISION HISTORY: 8/13/02, 3/17/03  
Initial Effective Date: 2/15/02  
Biannual Review Date:

File Ref:  
A6800

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT:</b> Re-credentialing of Licensed Health Care Professionals	<b>Number:</b>	<b>80.308.1</b>
--	----------------	-----------------

into consideration during the re-credentialing decision-making process as well as an ongoing provider network participation criteria during the period of approved full re-credential participation.

c. Sentinel Events Office Information

The Sentinel Events Office must be queried for reported sentinel events for the specific practitioner. The Sentinel Event Provider Incident Count Database in the Credentialing Unit will also be queried to establish any patterns of reported sentinel events during the credential period. This must be included in the practitioner's credential file and taken into consideration during the re-credentialing decision-making process as well as an ongoing provider network participation criteria during the period of approved full re-credential participation.

d. Medical Suspension/Termination Rights

Information from the Medicaid Suspension/Termination Report is reviewed to determine if the practitioner applicant has been previously suspended or terminated from Medicaid Programs participation. If the practitioner's name is found in the list, the information will be reported to the Committee for discussion and decision.

5. Notification to Authorities and Practitioner Appeal Rights

A. Range of actions

CAMHD reserves the right to rescind the full credentialing status of any practitioner that does not comply with State Ethics Standards, CAMHD standards, and State and Federal laws.

B. Reporting of serious quality deficiencies that could result in a practitioner's suspension, termination, and/or reporting to appropriate authorities. The decision letter is issued within five (5) working days and includes the reconsideration and appeal process stated in the "*Request for Reconsideration & Appeal Process*" section of this policy.

Discovery of any misrepresentation of credentials or other illegal activities will be discussed in the CAMHD Credentialing Committee meeting. Results of the discussion may warrant reporting the clinician's name and situation and will be

REVISION HISTORY: 8/13/02, 3/17/03  
Initial Effective Date: 2/15/02  
Biannual Review Date:

File Ref:  
A6800

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT:</b> Re-credentialing of Licensed Health Care Professionals	<b>Number:</b>	<b>80.308.1</b>
--	----------------	-----------------

referred to the CAMHD Compliance Committee for investigation, with a copy to the Provider Relations Officer. If warranted, licensed clinician's name may be referred to the designated Medicaid Investigator. CAMHD reserves the right to retain, suspend, or terminate any clinician that has misrepresented his or her credentials in any way that compromises services to the CAMHD children.

The CAMHD Fraud and Abuse Program outlines CAMHD's procedure for reporting serious quality deficiencies that could result in a provider's suspension or termination to the Medicaid Fraud Investigator as well as other appropriate authorities.

- C. CAMHD has an appeals process for instances in which it chooses to alter the conditions of the practitioner's participation based on issues of quality of care and/or service.

The *"Request for Reconsideration & Appeals Process"* applies for at any time the applicant disagrees with the CAMHD Credentialing Committee Decision. This process is included in all decision letters.

### 1. Interagency Transfer of Credential Status

Practitioner transfers occurring during active credentialing periods shall require verification of items within timeframes as listed in the *"CAMHD Licensed Provider Interagency Transfer Checklist"* as applicable. (**See Attachment J**) The Committee has authorized the CAMHD Credentialing Specialist to approve transfers if all criteria are satisfied. The names of the applicants approved to transfer will be reported in the next Committee meeting.

If a transfer was denied for any reason, the decision letter is issued within five (5) working days and includes the reconsideration and appeal process stated in the *"Request for Reconsideration & Appeal Process"* section of this policy.

### 2. MIS Registration of Credentialed Practitioner

All approved practitioner credential information are reported on a weekly basis by the CAMHD Credentialing Unit to CAMHD Management Information System (MIS) section to be registered in accordance to the established MIS clinician registration guidelines.

### 3. Credentialing Reports

#### a. Medicaid Reports

REVISION HISTORY: 8/13/02, 3/17/03  
Initial Effective Date: 2/15/02  
Biannual Review Date:

File Ref:  
A6800

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT:</b> Re-credentialing of Licensed Health Care Professionals	<b>Number:</b>	<b>80.308.1</b>
--	----------------	-----------------

CAMHD must submit to the Department of Human Services Med-QUEST Division (DHS-MQD), if required, a listing of its provider network. At a minimum, the list must include the name of the provider, their title, site address, and telephone number.

b. CAMHD Performance Improvement Steering Committee (PISC) Reports

The CAMHD Credentialing Committee must submit to PISC for review its performance measures for timeliness, quality, and effectiveness according to the PISC reporting schedule. The Chair or designated representative attends the PISC meetings.

c. CAMHD Contracted Agencies are required to submit electronically monthly reports of their current credentialed licensed staff in the format required by CAMHD.

### ATTACHMENTS:

- A. CAMHD Glossary of Credentialing Terms
- B. CAMHD Licensed Provider Re-credentialing Checklist, Rev. 10-01-04
- C. CAMHD Credentialing Committee Member Confidentiality Statement; Version July 2003
- D. CAMHD Licensed Provider Re-credentialing Application Form, Rev. 7-11-03
- E. CAMHD Attestation Letter, 7-11-03
- F. CAMHD Child Abuse and Neglect Request Form, Rev. 7-11-03
- G. CAMHD Child Abuse and Neglect Authorization Form, Rev. 8-9-04
- H. CAMHD Child Abuse and Neglect Negative Findings Generic Letter Format, July, 2004
- I. CAMHD Treatment Office Visit Tool; Rev. 11-01-04
- J. CAMHD Licensed Provider Interagency Transfer Checklist; Rev. 8-09-04

REVISION HISTORY: 8/13/02, 3/17/03  
Initial Effective Date: 2/15/02  
Biannual Review Date:

File Ref:  
A6800

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT:</b> Grievances and Grievance Appeals	<b>Number:</b>	<b>80.603</b>
<b>REFERENCE:</b> Hawaii Administrative Rule§11-175-34; Title 45 C.F.R. §164.502(b), 164.530; 42 C.F.R. §§438.210(d)(2)(i), 438.406(a)(1), 438.408(c)(2); HRS §334; HRS 622 (Part V), Medical Records; HRS [Chapter 92F]	<b>APPROVED:</b>	
	<i>Signature on File</i>	July 15, 2003
	Chief	Eff. Date

### PURPOSE

To manage a systematic process for registering, tracking, resolving, and reporting grievances and grievance appeals filed by consumers, families, providers, Child and Adolescent Mental Health Division (CAMHD) personnel, or other concerned parties.

### DEFINITION

**Aggrieved Party** – The person who is filing a grievance or on whose behalf the grievance or grievance appeal is being filed.

**Branch** – A CAMHD Family Guidance Center or Family Court Liaison Branch.

**Consumer** – Youth with emotional and/or behavioral challenges receiving intensive mental health services from CAMHD. For the purposes of this policy the definition of “consumer” may include the youth’s parent(s), legal guardian or designated third party representative.

**Default Determination** – An alternative determination made by the GO in cases where a party to a grievance fails to respond to an inquiry by the GO or fails to produce requested documents by the given response date, or within a reasonable time thereafter.

**HIPAA Complaint** – Any assertion, whether written or oral, that an unauthorized disclosure of protected health information was made in violation of HIPAA regulations by CAMHD.

**Grievance** - Any oral or written communication, made by or on the behalf of a consumer, provider, and others that expresses dissatisfaction with any aspect of the CAMHD operations, activities, behavior, or providers and its sub-contractor(s), except in matters regarding the termination of a contract or a non-extension of a contract that is eligible for extension. Such appeals are addressed in another policy.

**Grievance Review** –A Med-Quest review process of a denied, unresolved, or unfavorable findings and conclusions, made on behalf of a Med-Quest youth at the CAMHD grievance level. The Grievance Review process is not open to grievances that merely involve a Med-Quest youth (e.g., provider reimbursement for services to a Med-Quest youth, etc.).

**Grievance Appeal** – A written request made by, or on behalf of a non-Med-QUEST consumer or provider for review by the Grievance and Appeals Committee of an adverse

REVISION HISTORY: 3/21/01, 3/25/03  
INITIAL EFFECTIVE DATE: 12/15/99

File Ref:  
A6420

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT:</b> Grievances and Grievance Appeals	<b>Number:</b>	<b>80.603</b>
--	----------------	---------------

*grievance decision; or for review by the Appeals Board of an adverse Grievance and Appeals Committee decision.*

***Grievance Management System (GMS)*** - *The designated system that has the responsibility to address and resolve a grievance or an appeal of an action. The Grievance Office (GO), the CAMHD Privacy Coordinator, Claims Review Section, and the Branch's Quality Assurance Specialist are the primary GMS. As a grievance may actually be an appeal of an action, the CAMHD Clinical Services Office (CSO) is also considered a GMS.*

### POLICY

1. CAMHD shall insure that all consumers and providers are informed of, understand, and make effective use of the grievance and appeal processes outlined in this document. The CAMHD shall inform all consumers and providers of the two portals through which they can access the CAMHD's grievance system and how he/she/they can receive assistance in communicating the grievance.
2. All concerns brought to the CAMHD's attention by anyone shall be addressed, investigated, and resolved in timely fashion as can reasonably be expected, by all parties with a vested interest in the issues at hand. Where there is the possibility that the thirty (30) day timeline (along with the fifteen (15) day extension) will not be met because of a party's inaction or inability (e.g., a pending court proceeding, due process hearing, etc.), a default determination will be made against the party that does not reply or provide requested documents to the GO by the stated response date. A default determination does not resolve any substantive issue where the fact(s) remain in dispute. However, if a grievance involves a particular staff's conduct (e.g. abuse, assault, questionable billing, etc.) the staff's name will be forwarded to the CAMHD's Credentialing Committee for review and possible restriction on providing services for their current, or any future provider, until the issue is resolved.
3. All CAMHD personnel shall cooperate fully with any investigation and resolution of grievances.
4. All corrective measures, deemed warranted, shall be executed in a timely manner.
5. When using or disclosing protected health information or when requesting protected health information from another covered entity, CAMHD must make reasonable efforts to limit protected health information to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request. 45 C.F.R. §164.502(b). To determine minimum necessary, refer to *P&P 80.407, "Release of and Access to Confidential Information About Consumers."*

REVISION HISTORY: 3/21/01, 3/25/03  
INITIAL EFFECTIVE DATE: 12/15/99

File Ref:  
A6420



# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT:</b> Grievances and Grievance Appeals	<b>Number:</b>	<b>80.603</b>
--	----------------	---------------

6. Pursuant to HRS §92F(1) and (3), the CAMHD shall recognize an aggrieved party's request to keep their identity anonymous.

### PROCEDURE

#### I. GENERAL

Upon receipt of a call from a consumer, provider or subcontractor, the Branch or GO staff will interview the person making the call, while at the same time, using the *"CAMHD Discernment Tool,"* (See Attachment 1) assess the type of call, e.g., inquiry, grievance, grievance appeal, or HIPAA complaint. The BRANCH or GO staff shall also determine if the person at issue is a Med-QUEST enrollee (through monthly Med-Quest log to be provided by CAMHD's Quest Plan Coordinator).

- A. If the issue is determined to be a grievance, the grievance must be filed with CAMHD within thirty (30) calendar days of the date of the occurrence. Grievances may be filed with CAMHD in the event of dissatisfaction or disagreement with:
1. Availability of mental health services (may be discerned as an action);
  2. Delivery of services;
  3. Quality of services;
  4. Individual staff;
  5. Provider agency and its sub-contractors;
  6. Payment/Billing;
  7. Any aspect of the performance of Branch staff; or
  8. Performance of CAMHD Central Administration Offices or staff.
- B. All referrals to the CAMHD shall include the name, address and phone number of the aggrieved party, the nature of the grievance, and documentation of actions taken prior to the referral.
- C. All expressions of dissatisfaction, regardless of the degree of perceived seriousness, relating to quality of care, availability and delivery of mental health or support services performed by the CAMHD personnel or the CAMHD contracted providers, shall be investigated and responded to by either the BRANCH's Quality Assurance Specialists (QAS) or the Grievance Office (GO).

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT:</b> Grievances and Grievance Appeals	<b>Number:</b>	<b>80.603</b>
--	----------------	---------------

- D. Grievances concerning billing, nonpayment or delay in reimbursement will be referred to, investigated and responded to by the CAMHD Claims Review Section.
- E. HIPAA Complaints, whether from a consumer, provider, or BRANCH, concerning unauthorized disclosure of protected health information (PHI) in violation of HIPAA regulations, will be initially processed through the GO (e.g., logged into database as a complaint, etc.). The complaint will then be forwarded to the CAMHD Privacy Coordinator for acknowledgement and resolution within HIPAA established Timelines. *See P&P 80.603.1, "Individual Right to File Complaints About Compliance with Privacy Policy and Procedures."*
- F. If the call is determined to be an inquiry, the BRANCH staff will address the inquiry and forward the information the GO via the CAMHD Monthly Grievance Information Log.
- G. If an inquiry is later determined to be a grievance, the GO will contact the caller to confirm if the caller wants to pursue the inquiry as a grievance. If the caller chooses to pursue a grievance, the thirty (30) day grievance resolution timeline begins as of the day that the GO contacted the caller.

## II. GRIEVANCE MANAGEMENT

There are two (2) portals through which a consumer, provider, or its sub-contractor can access the CAMHD's grievance system. The aggrieved party can either call a BRANCH or call the GO directly. Once staff has determined the type of call, the call will be forwarded to the appropriate GMS. With the exception of grievances that involve QAS investigation of sensitive issues, the QAS has the option to resolve or forward a grievance to the GO (i.e., grievance about administration, etc.). The grievance should be resolved by the GMS that received the call. **(See Flowchart Attachment 2)**

### A. BRANCH Portal

Upon the BRANCH receipt of a call by the consumer or provider, the BRANCH GMS will:

- 1. Register the call.
  - a. The BRANCH staff taking the call will record caller's name (if different from the aggrieved party, and the aggrieved person's name) and the phone number and address of the aggrieved.

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT:</b> Grievances and Grievance Appeals	<b>Number:</b>	<b>80.603</b>
--	----------------	---------------

- b. The BRANCH staff will document the name of the assigned Mental Health Care Coordinator (MHCC) and the date of the call.
  2. Document substance of the call.
    - a. Give consumers any reasonable assistance in completing forms, framing the issues, and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capabilities.
    - b. The BRANCH staff taking the call will attempt to obtain the general nature of the call. The staff taking the call will note what they perceive as the issue and forward that information to the appropriate GMS.
    - c. Complete weekly "*CAMHD Grievance Intake Form*" (See **Attachment 3**), and submit to the GO.
  3. Discern whether the call is an inquiry, grievance, or an appeal of an action, and link to that GMS.
    - a. Using the "*CAMHD Discerning Tool*," the BRANCH staff will ask the caller a series of questions that will give a preliminary determination of whether the call is an inquiry, an appeal, or a grievance. Once the nature of the call is determined, the BRANCH staff will:
    - b. Forward the call to the QAS (if it is a grievance); and
    - c. Upon receipt of a grievance, BRANCH personnel will complete the "*Grievances Intake Form*."
    - d. Resolve the call (if the call is a simple inquiry); or
    - e. Forward the call to CSO (if the call is an appeal of an action).
    - f. If the BRANCH QAS determines that a grievance involves an administrator of the BRANCH, the QAS has the option to forward the grievance directly to the GO. Should the QAS choose to forward the grievance to the GO, this must be accomplished immediately (within twenty-four (24) hours of receipt of the grievance), in order for the GO to meet the prescribed timelines. If the QAS chooses to retain the grievance, the timelines listed in the "Timelines" section applies and must be adhered to.

<b>SUBJECT:</b> Grievances and Grievance Appeals	<b>Number:</b>	<b>80.603</b>
--	----------------	---------------

- REVISION HISTORY: 3/21/01, 3/25/03  
INITIAL EFFECTIVE DATE: 12/15/99

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT:</b> Grievances and Grievance Appeals	<b>Number:</b>	<b>80.603</b>
--	----------------	---------------

make all appropriate referral(s), e.g., sentinel events, police, CPS, etc.

- b. Should misconduct, attributed to a provider, be determined as the result of a grievance investigation, the investigating body will also report this information to CAMHD's Credentialing Unit.

### 7. Timelines.

Pursuant to 42 CFR §438.406 and 45 CFR §160.306(b)(3), it is necessary to follow the timelines for each step of a grievance:

- a. *HIPAA Timelines:* 1) One hundred eighty (180) days for aggrieved party to file from the day they knew, or should have known of the breach; and 2) Thirty (30) days to address and mitigate.
- b. *Expedited Appeals:* 1) Immediate verbal acknowledgement; 2) Two (2) days written acknowledgement; and 3) Three (3) Business days resolution. If denied, timeframe shifts to regular appeals process.
- c. *Med-Quest Grievances:* 1) Five (5) days to acknowledge; 2) Thirty (30) days to investigate and make a determination, Fifteen (15) days extension for cause; 3) Thirty (30) days to file for a Grievance Review (from day of receipt of determination); and 4) Thirty (30) days for Med-Quest to conclude the Grievance Review.
- d. *Non-Med-Quest Grievances:* 1) Five (5) days to acknowledge; 2) Thirty (30) days to investigate and make determination, Fifteen (15) days extension for cause; and 3) Thirty (30) days for Grievance Appeals.

All timeframe references to days are "calendar" days, except where business days are mentioned. The aggrieved party or CAMHD can request an extension (if CAMHD can show how the delay is in the recipient's interest).

### 8. Notify consumers of disposition and appeal rights (emphasize importance/clarity of response).

On, or before the thirty (30) day investigation period ends and a determination has been made by the QAS, a letter of determination shall be drafted. The content of the letter should: 1) Summarize the issue(s) of

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT:</b> Grievances and Grievance Appeals	<b>Number:</b>	<b>80.603</b>
--	----------------	---------------

the grievance; 2) Explain the decision, the decision making process and logic; and 3) Conclude with a paragraph stating the Aggrieved Party's right to file for a Med-Quest Grievance Review. The QAS will then forward copies of the determination letters accordingly:

- a. The original to the Aggrieved Party;
- b. One copy to the GO; and
- c. One copy to file.

9. Data tracking/Reporting.

- a. The QAS will complete a grievance intake form and log the grievance; and
- b. The QAS will forward the log and intake form (each Monday of the following week) to the GO. The GO will enter the grievance into the database.
- c. Report all negative grievances in the log and fax to the GO, regardless if the form contains no data.
- d. The MHCC or QAS (or PHAO in the QAS's absence) of each BRANCH is responsible for faxing the "*CAMHD Weekly Information Log*" (*See Attachment 5*) for grievances, grievance appeals, and HIPAA complaints, generated the previous week to the GO by 4:00 p.m. each Monday. If the Weekly Information Log contains a consumer's protected health information (PHI), proper faxing protocol must be followed pursuant to *P&P 80.402*, "*Confidentiality, FAX Transmission.*"

B. Grievance Office (GO) Portal

Central Administrative Responsibilities include:

1. Grievances concerning fiscal matters by the GO are forwarded to the designated Claims Review personnel for investigation and response. The Claims Reviews staff is responsible for inputting case information in the Grievance Tracking Database System, and for following the procedures in this manual to initiate and complete the investigation.
2. For cases that are referred to the GO for investigation, the GO will assist the aggrieved party in determining the substantive issue(s) of the case and provide the aggrieved party with a written acknowledgement within five (5) workdays from receipt of the grievance. All information will be

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT:</b> Grievances and Grievance Appeals	<b>Number:</b>	<b>80.603</b>
--	----------------	---------------

recorded in the Grievance Tracking Database System. Investigations will begin within seven (7) workdays from the date the complaint is filed.

3. The investigative and resolution portion of the complaint process will not exceed thirty (30) calendar days. It will begin with a discussion with the Mental Health Care Coordinator regarding the child's history if the nature of the complaint is specific to a child.
4. Extensions are permitted only if exceptional circumstances exist with respect to a particular grievance. Any extension cannot exceed 15 calendar days. The investigating party will maintain documentation on extensions, including the rationale for the extension and the new date for issuance of findings. Exceptional circumstances may include but are not limited to:
  - a. The need to review documents or information that will not be available until after the thirty (30) day time limit;
  - b. Unusually complex issues or extraordinarily high volume of documents;
  - c. Extensive number of issues; or
  - d. Temporary unavailability of individuals with information critical to the complaint.

In the event a fifteen (15) day extension is needed, a notice will be mailed to the aggrieved party three (3) days prior to the expiration of the thirty (30) day timeframe and will set forth the reason for the requested extension along with the revised deadline date.

5. In resolving grievances, the investigating party will follow the CAMHD "Interagency Performance Standards and Practice Guidelines" and all applicable laws. Other Central Administration or BRANCH staff may be consulted or asked to assist in this fact-finding process. On-site reviews by Clinical Services and Performance Management may be requested as necessary.
6. Response: The investigating party (BRANCH, GO, or Claims Review Section) will respond to the aggrieved party in writing. The "*Letter of Resolution*" (**See Attachment 6**) must include the following information:
  - a. Name and address of the aggrieved party;
  - b. Date of notification and date when grievance was originally filed with the GO;

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT:</b> Grievances and Grievance Appeals	<b>Number:</b>	<b>80.603</b>
--	----------------	---------------

- c. Name of the staff investigator;
- d. Findings;
- e. Corrective action plan, if needed;
- f. A concluding paragraph (for Med-QUEST consumers only) that states: *“This letter is the CAMHD GO’s decision. If you do not agree, you may ask for a Grievance Review. Submit a written request for a Grievance Review with the Med-QUEST Office within thirty (30) calendar days of this notice. If you choose not to pursue a Grievance Review with the Med-QUEST Division, the GO’s decision is the final resolution of your grievance. You can write in care of: Med-QUEST Division, Health Coverage Management Branch, 601 Kamokila Blvd., #506, Kapolei, Hawaii, 96707.”*

For non-Med-QUEST consumers, the concluding paragraph must state: *“This letter represents the CAMHD GO’s decision. If you do not agree, you may file an appeal within thirty (30) calendar days of this notice. Please call or write the CAMHD Grievance Office to file the appeal. If you choose not to appeal, this is the final resolution of your grievance. The CAMHD Grievance Committee will hear your appeal. Please send your written request together with any supporting documentation to the Grievance Office, 3627 Kilauea Ave., Room 101, Honolulu, Hawaii 96816. Should you have any questions you can contact the GO at (808) 733-9352,”* and

- g. In grievances involving direct service providers and delegated activities contractors, a copy of the Resolution letter should be provided to the Credentialing Unit or other CAMHD administrative section as applicable (*i.e.*, performance monitoring unit).
7. Calls To The GO: Upon the GO receipt of a call by the consumer, third party representative, or provider, the GO GMS will:
- a. Register the call.
    - 1) The GO taking the call will record:
      - (a) Callers name (if different from the aggrieved party, and the aggrieved person’s name), phone number and address of the aggrieved party;

REVISION HISTORY: 3/21/01, 3/25/03  
INITIAL EFFECTIVE DATE: 12/15/99

File Ref:  
A6420



# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT:</b> Grievances and Grievance Appeals	<b>Number:</b>	<b>80.603</b>
--	----------------	---------------

- (b) The consumer's client record (CR) number and/or Med-Quest ID number;
  - (c) The assigned MHCC;
  - (d) The date of the call; and
  - (e) Log grievance into the GO Database.
- b. Document substance of the call.

The GO staff taking the call will attempt to obtain the general nature of the call and note what they perceive as the issue and either resolve the grievance within prescribed timelines, or forward that information to the appropriate GMS.
- c. Discern whether the call is an inquiry, grievance, or an appeal of an action, and link to that GMS.
  - 1) Using the Discerning Tool, the GO staff will ask the caller a series of questions that will give a preliminary determination of whether the call is an inquiry, a grievance, or an appeal of an action. Once the nature of the call is determined, the GO will:
  - 2) Resolve the call (if the call is a simple inquiry);
  - 3) Address the grievance as noted above;
  - 4) Should a grievance be retained by the GO, the GO must send a letter of acknowledgement to her aggrieved party within five (5) days from receipt of the grievance.
  - 5) Forward the call to CSO if: 1) the call is an appeal of an action, or 2) notwithstanding the timeframes set fourth in *P&P 80.604, "Denial of Services, Appeals, & Med-Quest Hearing Process,"* the action had been implemented without (i) the consumer receiving proper notice, and/or (ii) appeal rights (unless such a procedural error results in a grievance); or
  - 6) Forward the complaint to the CAMHD Privacy Coordinator (if the call is a HIPAA issue).
- d. If the call is determined to be a grievance, investigate the substance of the grievance including:

REVISION HISTORY: 3/21/01, 3/25/03  
INITIAL EFFECTIVE DATE: 12/15/99

File Ref:  
A6420

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT:</b> Grievances and Grievance Appeals	<b>Number:</b>	<b>80.603</b>
--	----------------	---------------

- 1) Clinical issues involved:
  - (a) Obtain issues from the aggrieved party;
  - (b) Ask the caller what they expect the outcome to be, e.g., just to inform CAMHD, investigate, etc.; and
  - (c) Interview MHCC and provider.
- 2) All pertinent documentation:
  - (a) Request all necessary documents in CAMHD's possession from MHCC or QAS (i.e., IEP, CSP, MHTP, etc.);
  - (b) Request other necessary documents not in CAMHD's possession (written statements, impressions, etc.), from providers, teachers, etc.; and
  - (c) Consult the CAMHD CASSP Principles and IPSPG.
- 3) Clinical, administrative, or other consultation from:
  - BRANCH Clinical Director;
  - MHS and Branch Chief; and/or
  - CAMHD Medical Director (CSO).
- e. Make a determination based upon the information obtained from the investigation, within thirty (30) calendar days from receipt of the call, the GO will conclude the investigation and make a determination on the issue(s).
- f. Managing clinically urgent grievances.
  - 1) The staff that makes the discovery must address all clinically urgent grievances, such as abuse. That staff is obligated to make all appropriate referral(s), e.g., sentinel events, police, CPS, etc.
  - 2) Should misconduct, attributed to a provider, be determined as the result of a grievance investigation, the investigating body will also report this information to CAMHD's Credentialing Unit.

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT:</b> Grievances and Grievance Appeals	<b>Number:</b>	<b>80.603</b>
--	----------------	---------------

g. Timelines.

Pursuant to 42 CFR §438.406 and 45 CFR §160.306(b)(3), it is necessary to follow the timelines for each step of a grievance:

- 1) *HIPAA Timelines*: 1) One hundred and eighty (180) days for aggrieved party to file from the day they knew, or should have known of the breach; and 2) Thirty (30) days to address and mitigate.
- 2) *Expedited Appeals*: 1) Immediate verbal acknowledgement; 2) two (2)-day written acknowledgement; and 3) three (3) Business Day resolution. If denied, timeframe shifts to regular appeals process.
- 3) *Med-Quest Grievances*: 1) Five (5) days to acknowledge; 2) Thirty (30) days to investigate and make a determination, fifteen (15) days extension for cause; 3) Thirty (30) days to file for a Grievance Review (from day of receipt of determination); and 4) Thirty (30) days for Med-Quest to conclude the Grievance Review.
- 4) *Non-Med-Quest Grievances*: 1) Five (5) days to acknowledge; 2) Thirty (30) days to investigate and make determination, Fifteen (15) days extension for cause; and 3) Thirty (30) days for Grievance Appeals.

All timeframe references to days are “calendar” days, except where business days are mentioned. The aggrieved party or CAMHD can request an extension (if CAMHD can show how the delay is in the recipient’s interest).

h. Notify consumers of disposition and appeal rights (emphasize importance/ clarity of response).

Once the GO staff has made a determination, a letter of determination shall be drafted. The content of the letter should: 1) Summarize the issue(s) of the grievance; 2) Explain the decision, the decision making process and logic; and 3) Conclude with a paragraph stating the Aggrieved Party’s right to file for a Med-Quest Grievance Review (Med-QUEST case), or to file for a first-level appeal (Non-Med-QUEST cases). The GO will then forward copies of the determination letters accordingly:

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT:</b> Grievances and Grievance Appeals	<b>Number:</b>	<b>80.603</b>
--	----------------	---------------

- 1) The original to the Aggrieved Party;
  - 2) One copy to the Supervisor of Performance Management;
  - 3) One copy to the Med-QUEST plan liaison (Med-Quest case);
  - 4) One copy to file.
- i. Data tracking/Reporting.
- 1) The GO staff will receive and track the intake form from the QAS and log and enter the data into the GO database; and
  - 2) The GO staff will enter the grievance and its resolution into the Grievance database.
  - 3) The GO will generate all tracking and trending reports/analysis and submits the reports to the appropriate committees, i.e., Performance Information Steering Committee Report and Med-Quest Division Report.

### III. ACTIONS

- A. If the BRANCH staff determines that the nature of the call is regarding an action, the call is immediately referred to the QAS.
- B. The QAS will (within twenty-four (24) hours of receipt of call) forward the Aggrieved Party to the Clinical Services Office (CSO).
- C. Appeals, along with applicable Timelines, are addressed pursuant to *P&P 80.604, "Denial of Services, Appeals, and the State Fair Hearing Process."*
- D. If the GO determines that the nature of the call is in regard to an action, the GO will immediately forward the call, along with all pertinent information the GO receives, to CSO for resolution.
- E. If the GO or QAS receives a written grievance (from a parent or 3<sup>rd</sup> party representative) that is determined to be an action, the GO will immediately forward all necessary information to CSO and the appropriate BRANCH's MHCC and CD. The thirty (30) day resolution timeline begins when the GO has made the determination that the grievance is an action.

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT:</b> Grievances and Grievance Appeals	<b>Number:</b>	<b>80.603</b>
--	----------------	---------------

### IV. OTHER CENTRAL ADMINISTRATION OFFICE (CAO) DUTIES

- A. DOE: The GO may assist the Complaints Resolution Office of the Department of Education to investigate mental health related complaints about youth filed with the DOE. The investigation will follow DOE complaint procedures.
- B. Files: All grievances files will be maintained in a secured file marked with the grievance case number and the name of the aggrieved party.
- C. QAS Training on the Grievances Process: The CAO will train all QAS on the grievance process in order to assure consistent application of the process and procedures at the BRANCH level. The training will occur annually, at new employee orientation for the QAS, and when changes in the grievances process warrants re-training. The training will also explain the function and procedural process of grievances and appeals at the GO level. Training will include, but is not limited to:
  - 1. Logging all grievances received at the BRANCH level, whether resolved by the QAS or referred to the GO;
  - 2. The completion and submission of weekly reports to the GO for the purpose of tracking and trending;
  - 3. The role of the BRANCHs and the GO in the grievance process; and
  - 4. The exchange of critical case information between the GO and QAS.

### V. GRIEVANCE REVIEW (Med-QUEST)

- A. Consumers, families or providers who disagree with the findings and decisions at the grievance level may file for a “Grievance Review” with the Med-QUEST Division. Grievances reviews must be filed within thirty (30) calendar days of the date stated on the GO’s findings and decisions letter.
  - 1. All requests for a grievance review must be submitted to the Med-QUEST Division. Aggrieved parties who wish to pursue a grievance review must submit a written request to:

Med-QUEST Division  
Health Coverage Management Branch  
601 Kamokila Blvd., #506  
Kapolei, Hawaii 96707  
(808) 692-8093 or 692-8096

REVISION HISTORY: 3/21/01, 3/25/03  
INITIAL EFFECTIVE DATE: 12/15/99

File Ref:  
A6420

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT:</b> Grievances and Grievance Appeals	<b>Number:</b>	<b>80.603</b>
--	----------------	---------------

2. The Med-QUEST Plan Liaison must review the grievance and contact the recipient with a determination within thirty (30) calendar days from the day he/she received the request for a grievance review.
3. The grievance review determination made by the Med-QUEST staff is final.

### VI. GRIEVANCE (Non-Med-QUEST)

- A. The procedure and applicable Timelines for non-Med-QUEST grievances will be the same as Med-QUEST grievances. However, the appeal rights for non-Med-QUEST consumers will be handled according to internal CAMHD appeals protocol exclusive of Med-QUEST Division. Non-Med-Quest grievances must be filed with the GO within thirty (30) days of its occurrence or thirty (30) days from the time the aggrieved party knew, or should have known, of the grievance.
- B. Investigation of the grievance will be initiated within seven (7) workdays from the date the grievance is filed. The grievance process will not exceed thirty (30) calendar days. Extensions are permitted only if exceptional circumstances exist with respect to a particular grievance. Any extension will be for a specified duration of time, not to exceed fifteen (15) days. The investigating party will maintain documentation on extensions, including the rationale for the extension and the new date for issuance of findings. Exceptional circumstances may include but are not limited to:
  1. The need to review documents or information that will not be available until after the thirty (30) calendar day time limit;
  2. Unusually complex issues or extraordinarily high volumes of documents;
  3. Extensive number of issues;
  4. Temporary unavailability of individuals with information critical to the grievance; and
  5. Scheduling conflicts of the Grievance and Appeals Committee.
- C. Investigation Process (Non-Med-QUEST)
  1. The GO will receive written grievances, forwarding those that are fiscally related to the CAMHD Fiscal Section. Information related to all grievances shall be reviewed to insure all areas of the complaint processes have been exhausted prior to opening the grievance. Further fact-finding

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT:</b> Grievances and Grievance Appeals	<b>Number:</b>	<b>80.603</b>
--	----------------	---------------

shall be conducted of any significant new information brought forth by the written grievance.

2. The GO or the CAMHD Fiscal Section, as applicable, will notify the grieving party in writing of the receipt of the grievance. Either the GO or the CAMHD Fiscal Section as applicable shall enter case information into the shared Grievance Tracking Database System.
3. The GO shall prepare non-fiscal grievance reports for the Grievance and Appeals Committee's review, including any applicable new fact-finding information; the Claims Review Section will do the same for fiscal-related grievances.
4. All grievances pursuant to 42 CFR §438.400(b)(6), shall be addressed by the GO following the established guidelines and timelines defined by Med-Quest.

D. The Grievance and Appeals Committee (Non-Med-QUEST)

Pursuant to *P&P 80.509, "Grievance and Appeals Committee"*:

1. Grievance appeals are presented to the CAMHD Grievance and Appeals Committee at the next regularly scheduled meeting following the conclusion of the investigation. The committee will consist of a quorum of the following CAMHD staff: Clinical Director, Performance Management Supervisor, Provider Relations Specialist, BRANCH Representative, Fiscal Representative. The committee membership will also include a family resource representative.
2. The committee will render a decision upon hearing and reviewing the grievance report. This determination will be reported in writing to the grieving party within ten (10) working days of the decision. The party responsible for presenting the grievance at the committee meeting will prepare the response. The written response to the grieving party must include the following information:
  - a. Name and address of the aggrieved party;
  - b. Findings of the Grievance and Appeals Committee;
  - c. Corrective action plan;
  - d. Agreement (as to monetary disputes), if applicable; and
  - e. For all adverse decisions to a grievance, a concluding paragraph that notifies the grieving party of their right to file a second-level

REVISION HISTORY: 3/21/01, 3/25/03  
INITIAL EFFECTIVE DATE: 12/15/99

File Ref:  
A6420

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT:</b> Grievances and Grievance Appeals	<b>Number:</b>	<b>80.603</b>
--	----------------	---------------

appeal to the CAMHD Appeals Board, how to file the appeal, the timeline to filing, and the address of the GO.

- f. In the matter of fiscal grievances, CAMHD reserves the exclusive right to determine whether or not to engage in a settlement process.
- g. The grievance files will be maintained in a file marked with the grievance case number and the name of the grieving party. These files will be controlled as sensitive material and will be maintained on premises by the GO Office in a secure file cabinet.

### E. Settlement Process (Non-Med-QUEST)

1. The Grievance and Appeals Committee will consider the following factors in determining whether a settlement shall be offered based on the following factors:
  - a. Whether denial of the grievance will have a significant impact on the agency's ability to continue providing services to CAMHD identified youth. The existence of a significant impact will be determined by looking at the following:
    - 1) The amount requested/being appealed.
    - 2) The percentage of the appealed amount to the total amount the grieving party has billed CAMHD encompassing the preceding year to date.
  - b. Acceptable alternative documentation as proof of the provision of services consisting of:
    - 1) Clear evidence that the services in question were provided.
    - 2) The seriousness of the billing deficiency in relation to the compliance with the contractual documentation requirements, per level of care at issue.
  - c. The lack of evidence of a pattern of fraud and/or abuse.
  - d. The impact on CAMHD's ability to provide services to CAMHD youth.
2. Following a compilation of documentation related to all of the above factors, the Claims Review Section will present a written summary accompanied with a recommendation for offer of settlement for the Grievance and Appeals Committee's consideration and decision.



# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT:</b> Grievances and Grievance Appeals	<b>Number:</b>	<b>80.603</b>
--	----------------	---------------

3. It is within the CAMHD's sole discretion to determine the amount offered to a grieving party.
4. The Grievance and Appeals Committee's decision stands in the event a settlement is not offered.
5. Following a decision to offer a settlement, the Claims Review Section will send a written response to the grieving party that includes the following information:
  - a. Name and address of the grieving party;
  - b. Findings of the Grievance and Appeals Committee;
  - c. Corrective action plan, if needed; and
  - d. Agreement (as to monetary disputes), if needed.

### F. APPEALS (Non-Med-QUEST)

1. The aggrieved party may file a written appeal (2<sup>nd</sup> level appeal) with the GO if they disagree with the determination of the Grievance and Appeals Committee. The appeal of the Grievance and Appeals Committee's decision must be filed within thirty (30) calendar days of the date stated on the determination letter. It must include:
  - a. The reasons the complainant believes the Grievance and Appeals Committee's decision was in error;
  - b. All necessary facts and documents to support the reasons for appeal;
  - c. Any new information that was previously unavailable together with the reasons why the new information was not previously available; and
  - d. If applicable, a description of any extenuating circumstances.
2. The Grievance Office may dismiss a request for appeal if the request for appeal does not meet the foregoing requirements, for good cause, or where the request for appeal is frivolous and without merit. Any dismissal of a request for appeal shall be in writing and state the reasons for dismissal.
3. The GO or the Claims Review Section as applicable, upon receipt of the written appeal, will review the information to ensure all areas of the grievance process have been exhausted prior to opening the appeal. The applicable office will enter all pertinent information into the Grievance

REVISION HISTORY: 3/21/01, 3/25/03  
INITIAL EFFECTIVE DATE: 12/15/99

File Ref:  
A6420

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT:</b> Grievances and Grievance Appeals	<b>Number:</b>	<b>80.603</b>
--	----------------	---------------

Tracking Database system and the appealing party notified in writing of the receipt of the appeal.

4. The appealing party has the right to submit documentation in support of the appeal or appear in person before the CAMHD Appeals Board. The GO or the Fiscal Section as applicable will inform the appealing party of the appeal date as soon as one can be scheduled.
5. A synopsis of the case on appeal will be prepared by the GO (non-fiscal cases), or the Claims Review Section (fiscal cases). The GO will coordinate the forwarding of the synopsis to the CAMHD Appeals Board for briefing purposes.
6. Pursuant to HAR §11-175-34(c), the appeals process will not exceed thirty (30) calendar days from receipt of the appeal. Extensions are permitted only if exceptional circumstances exist with respect to a particular appeal. Any extension will be for a specific amount of time. The GO or the Claims Review Section, as applicable, will maintain documentation on the extension, including the rationale for the extension and the new date for issuance of findings. Exceptional circumstances may include but are not limited to:
  - a. The need to review documents or information that will not be available until after the thirty (30) day time limit.
  - b. Unusually complex issues or extraordinarily high volume of documents;
  - c. Extensive number of issues; or
  - d. Temporary unavailability of individuals with information critical to the appeal; and
  - e. Scheduling conflicts of the CAMHD Appeals Board.
7. If CAMHD extends the timelines, it must – for any extension not requested by the consumer, give the consumer written notice of the reason for the delay.
  - a. The CAMHD Appeals Board consists of the Deputy Director for Behavioral Health, the CAMHD Chief and the Medical Director.
  - b. After the consumer files an appeal and before the CAMHD Appeals Board hears the case, the GO and the Claims Review Section may engage in efforts at settlement with the appealing

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT:</b> Grievances and Grievance Appeals	<b>Number:</b>	<b>80.603</b>
--	----------------	---------------

party. The procedures for settlement outlined in the "Settlement Process Section," will be followed.

- c. The CAMHD Appeals Board, after hearing and reviewing the appeal, will render a decision. This decision will be reported in writing to the appealing party within ten (10) working days of the decision. The decision of the CAMHD Appeals Board will be the final response from the CAMHD.
- d. Appeal files will be maintained in a file marked with the appeal case number and name of the appealing party. These files will be controlled as sensitive material and will be maintained on premises in a secure file cabinet.

### **G. DISMISSAL (Non-Med-QUEST)**

The CAMHD has the discretion to dismiss a grievance or appeal at any time upon written request from the initiating party or when the aggrieved party has failed to pursue or present their case, after reasonable notice by the CAMHD, after one (1) year of the initiation of the grievance or appeal. Upon a showing of good cause, the aggrieved party can request a reinstatement of their case.

### **H. REQUEST FOR PRODUCTION (Response and Documents)**

Should the party upon whom the request is served (non-moving party) fail to respond to the GO's inquiry within the stated time, or fail to produce any requested documents, the GO will find against that party. Prior to the resolution deadline, and upon a showing of good cause, the non-moving party can request to have their response and/or documents admitted.

### **I. CREDENTIALING (Provider Misconduct)**

Pursuant to an investigation, and upon a final determination, the GO will notify the Credentialing Section of any acts of misconduct of a CAMHD contracted provider. The GO will also notify the Credentialing Section of any ongoing investigation(s) regarding an allegation of provider misconduct. This information will consist of the provider's name, affiliation, the nature of the allegation, along with the GO's determination. The GO will also respond to requests for information for the purpose of Credentialing clearance reviews and for provider/staff in the process of re-credentialing.

## **VII. CONFIDENTIALITY/HANDLING**

Access to records will be limited to those staff members directly involved in the investigation of the grievance or appeal as well as managerial staff on a need to know

REVISION HISTORY: 3/21/01, 3/25/03  
INITIAL EFFECTIVE DATE: 12/15/99

File Ref:  
A6420

# INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

## CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT:</b> Grievances and Grievance Appeals	<b>Number:</b>	<b>80.603</b>
--	----------------	---------------

basis. When not in use, records will be stored in a locked drawer or cabinet. Records will not be left unattended or unsecured in the workplace, or in a position or location easily accessible to non-staff members.

### VIII. RECORD RETENTION

All records of persons served by CAMHD will be maintained in a protected and confidential manner for time periods consistent with applicable laws.

- A. Records pertinent to minors shall be maintained for a period of twenty-five (25) years from the date of majority.
- B. The CAMHD will maintain records of all grievances and appeals for two years on site (current and last calendar year), with the remaining years being maintained in secure storage.

### IX. REQUEST FOR GRIEVANCE RECORDS

- A. Should the GO/QAS receive a request for access to any grievance documents, the GO/QAS will inform the requesting party any information contained in a CAMHD record may be subject to access by the public at the conclusion of the investigation and upon a requesting party's completion of a "Request to Access a Government Record" form through OIP (see attachment 7). HRS §92F-12(b)(2).
- B. The GO/QAS must complete and attach a "Notice to Requestor" form to GO's written response to anyone requesting access to information regarding the filed grievance. The response, if requested by the aggrieved party, will bar any identifying references to the aggrieved party and the Notice to Requestor will set forth, *inter alia*:
  - 1. Timeframe of the response;
  - 2. Any costs for the production of documents;
  - 3. Exceptions that would either (i) deny the request in its entirety, (ii) grant the request in full, or (iii) only as to certain parts; and
  - 4. Citation(s) to the appropriate statute and a brief explanation.
- C. Should an aggrieved party request anonymity, the GO/QAS will:
  - 1. Advise the aggrieved party that the release of any identifying information contained in a government record under HRS §92F-12(b)(2) is excepted under §92F-13(1), (3). Identifying information of a complainant in an individual's own personal record under HRS § 92F-21 is excepted under HRS § 92F-22(2), where the source who furnished information did so under "[A]n express or implied promise of confidentiality.

REVISION HISTORY: 3/21/01, 3/25/03  
INITIAL EFFECTIVE DATE: 12/15/99

File Ref:  
A6420

## INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

### CHILD AND ADOLESCENT MENTAL HEALTH DIVISION POLICY AND PROCEDURE MANUAL

<b>SUBJECT:</b> Grievances and Grievance Appeals	<b>Number:</b>	<b>80.603</b>
--	----------------	---------------

2. Advise the aggrieved party that to ensure his/her anonymity he/she should not disclose his/her name, address, phone number or other identifying information to the GO or QAS.
3. Assign a “Doe” name to the aggrieved party along with the five (5) digit grievance sequence number assigned by the GO database (i.e., “Mr./Ms. Doe 00335”) for reference.
4. Advise the aggrieved party to do the following to allow for sharing of information necessary to address the grievance filed. The aggrieved party should be instructed to do the following:
  - a. Pick-up CAMHD’s acknowledgement letter, indicating the receipt of the grievance, within three (3) days of the aggrieved party’s initial call at the GO or QAS. The letter may be picked up from the CAMHD
  - b. Contact the GO ten (10) days after the initial contact [in the event that the GO requires additional information from the aggrieved party];
  - c. Contact the GO three (3) days prior to end of the thirty (30) day resolution timeline in order for the GO to notify aggrieved party of any resolution or need to do an extension of fifteen (15)-days; and
  - d. Arrange to pick-up the CAMHD’s final determination letter at the CAMHD.

#### ATTACHMENTS:

1. CAMHD Discernment Tool
2. CAMHD Grievance Flow Chart
3. CAMHD Grievance Intake Form
4. CAMHD Sample Letter of Acknowledgement
5. CAMHD Weekly Grievance Information Log
6. CAMHD Letter of Resolution
7. Request to Access a Government Record (OIP)
8. Notice to Requestor (OIP)